THE UNIVERSITY of EDINBURGH

‘Balancing Complexity, Resources and Demand’.

A grounded theory of clinical decision making in psychological therapy for older people with posttraumatic stress symptoms.

Jane Billett

Doctorate in Clinical Psychology

University of Edinburgh

August 2013

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ACKNOWLEDGEMENTS

I would like to thank my supervisors, Dr Andrew MacDougall, Professor Mick Power and Dr Ethel Quayle for their constructive feedback and advice at all stages of the project. I will always be grateful to the Highland Older Adults Clinical Psychology Service for their continued support and encouragement over the past six years. Last, but not least, I would like to express my gratitude to the participants who gave up their precious time to be interviewed. Not only would there not have been a project without you, your passion and enthusiasm were inspiring.

DEDICATION

This thesis is dedicated to my family, to whom I owe everything.

CONTENT AND FORMAT

Chapter 1, Systematic Review, is written in accordance with the author guidelines issued by Clinical Psychology Review (see Appendix 1)

Chapter 2, Journal Article, is written in accordance with the author guidelines issued by the Journal of Loss and Trauma (see Appendix 2)

Chapter 3, Methodology, adheres to the guidelines issued by the Doctorate in Clinical Psychology handbook, The University of Edinburgh.

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Thesis word count: 21,265

Thesis Abstract

Background: Preliminary evidence suggests there are differences in how older people and younger people with posttraumatic stress disorder (PTSD) present. However, currently little robust evidence exists relating to the presentation, assessment and intervention of PTSD in a rapidly ageing population. Faced with limited and conflicting evidence, clinical psychologists are reliant on their clinical expertise to make decisions in this context.

Method: Eight studies reporting current prevalence of PTSD in older people were systematically reviewed. Semi-structured interviews with eight clinical psychologists with experience of assessment and intervention of post-traumatic stress symptomology in older people were analysed according to grounded theory methods. The analysis abstracted categories of data to construct a substantive theory of clinical decision making in this context.

Results: Current and 12 month prevalence of PTSD ranged from 0.7% to 4.0% and 0.2% to 0.4% respectively. Partial PTSD was estimated at 1% to 10%. The quality of evidence limits the generalisability of the results. 'Balancing complexity, resources and demand' emerged from participants' accounts as the core theoretical category, underpinning decision making in this context. Seven sub-categories comprise the model, 'culture'; 'NHS'; 'clinician competencies'; "what the client brings"; 'reconciling understanding'; 'tailoring' and 'therapeutic relationship'.

Conclusions: PTSD appears to be relatively rare among older people but more research is required to better understand the presentation and prevalence of full and partial PTSD. The theoretical model is broadly consistent with extant literature pertaining to the adaptation of psychological therapy for older people, offering further detail on implementation and the influence of treatment non-specific factors.

CHAPTER 1

SYSTEMATIC REVIEW

The prevalence of posttraumatic stress disorder in community samples of older people: A systematic review of the literature.

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Abstract

Background: Posttraumatic stress disorder (PTSD) has been shown to have significant consequences for long term physical health and wellbeing. In order for services to provide adequate care to the ageing population, greater information is required regarding its prevalence in older people.

Objectives: To systematically review the quality and summarise the findings of studies reporting current or twelve month prevalence of PTSD in people aged over 60 years living in the community.

Results: Eight studies were included. Lifetime exposure to traumatic events varied between 36.3% and 55.9%. War related experiences appear to account for much of the variation. Current and twelve month prevalence of PTSD ranged from 0.7% to 4.0% and 0.2% to 0.4% respectively. Partial PTSD rates of between 1.0% and 10% were reported. The limited literature, varied quality of sampling, differences in measures and definitions limit the generalisability of findings.

Major conclusions: Current, twelve month and lifetime prevalence of PTSD in older people is lower than has been found in working age adults, although the quality of evidence is varied. Preliminary evidence suggests higher levels of partial PTSD may be of greater concern. More robust research using measures standardised for this client group is required for both full and partial PTSD.

Keywords: posttraumatic stress disorder; older people; prevalence; community

Word count: 7,441

Introduction

It is estimated that by 2030, the world will have one billion people aged 65 years or older, comprising 13 per cent of the total population (United Nations, Department of Economic and Social Affairs, Population Division, 2007). In the UK, it is predicted that by 2035, those aged 65 and over will account for 23 per cent of the total population (Office for National Statistics, 2012). Meanwhile, a recent report by the House of Lords, Select Committee on Public Service and Demographic Change (2013) has deemed the UK government and society to be "woefully unprepared" for the challenges this demographic shift presents.

One aspect of this challenge is in meeting the mental health needs of this rapidly expanding group. In order for governments and health services to be in a position to provide adequate care to older people, more information is required to understand the prevalence, comorbidity, mediators and consequences of mental health problems (Laidlaw & Pachana, 2009). Although increasingly robust evidence regarding some mental health conditions in older people is emerging, research into posttraumatic stress disorder (PTSD) has been largely neglected (Bottche, Kuwert & Knaevelsrud, 2012).

The recent publication of the Diagnostic and Statistical Manual of Mental Diseases (DSM-5: American Psychiatric Association, 2013) has revised the criteria for PTSD. However, the majority of the studies included in the current review used the DSM-IV (APA, 2000) criteria, which are therefore summarised here. In order to meet these criteria an individual must demonstrate symptoms across six categories. First, the person must have experienced or witnessed a traumatic event involving actual or threatened death, serious injury and responded with intense fear, horror or helplessness (Criterion A). Second, the event is persistently re-experienced via intrusive symptoms, such as intrusive recollections, nightmares or flashbacks (Criterion B). Third, the person avoids trauma-related stimuli and

feels emotionally numb (Criterion C). Fourth, the person has symptoms of increased arousal such as hyper-vigilance, irritability or difficulty sleeping (Criterion D). Fifth, the duration of symptoms (according to Criteria B, C & D) last for more than a month (Criterion E). Lastly, symptoms cause clinically significant distress and impairment in functioning (Criterion F).

Partial PTSD has been defined as endorsement of at least one symptom within each of Criteria B, C, and D, lasting at least one month (Criterion E), after the worst event that involved intense fear, helplessness, or horror, or actual or threatened death, serious injury, or threat to the individual's or someone else's physical integrity (Pietrzak, Goldstein, Southwick, & Grant, 2012).

Evidence regarding the implications of PTSD for older people and conditions which are associated with it is starting to emerge, such as the increased risk of coronary heart disease among men with current PTSD reported by Kubzansky, Koenen, Spiro, Vokonas and Sparrow (2007). Significantly worse general functioning, co-morbid depression and greater utilisation of physical and mental health services were found among those with PTSD in a community sample of older people in comparison to a control group without PTSD (van Zelst, Beurs, Beekman, Dyck, & Deeg, 2006). These findings remained significant when chronic physical illness, functional limitations, social network size, cognitive impairment, anxiety symptoms, and depression were controlled for. Similar results were found for those participants who met criteria for partial PTSD, suggesting that even at 'lower' levels of symptomology the impact upon health and wellbeing are significant. The sample of adults between the age of 55 and 85 years somewhat reduces the generalisability of these results to those over 65 years, and as a cross-sectional study causal links cannot be drawn.

Pietrzak, Goldstein, Southwick and Grant (2012), report findings from a community study in which those who had experienced PTSD at some time in their life were more likely to report

lifetime suicide attempt, have co-morbid depression, anxiety and misuse substances. Evidence has accumulated to suggest that older veterans with current PTSD are significantly more likely to misuse alcohol, have co-morbid depression and anxiety (Owens, Baker, Kasckow, Ciesla & Mahamed, 2005). Furthermore, Busuttil (2004) reports that PTSD is often mistakenly diagnosed as anxiety and or depression, resulting in poorer outcomes for patients.

Averill and Beck (2000) conclude that there are differences in the symptoms presented by older people and younger people with PTSD. Cook and O'Donnell (2005) pose the question of whether this represents a true difference in how PTSD is experienced, and to what extent this may be influenced by cohort effects and developmental changes. In a recent review which focused on the cognitive and cerebral changes associated with ageing and their interaction with trauma, Lapp, Agbokou & Ferreri (2011, p.865) conclude that "it is clear that the aging process in combination with PTSD presents a unique situation" and call for more research in the area. Cohort effects have been found to influence reporting of PTSD symptoms in veterans (Owens et al, 2005), with stigma playing a large role.

Therefore, the available evidence is suggestive of differences in the presentation of PTSD among older people. More information regarding the prevalence and presentation of PTSD in this group would assist accurate identification and intervention, which is essential to reduce distress in individuals, but also the significant cost to health and social care services.

A review (Wolitzky Taylor, Castriotta, Lenze, Stanley, & Craske, 2010) and meta-analysis (Volkert, Schulz, Martin Härter, Wlodarczyk, & Andreas, 2013) of anxiety disorders in older people have recently been conducted. However, both reviews included studies which defined older people as aged over fifty years. A cohort is defined as between seven and ten years, (Knight, 2004) and thus in the UK where services define older people as over the age of 65,

reviews incorporating two cohorts who would not yet be eligible for older peoples' services have the potential to provide biased information. Wolitzky Taylor et al. (2010) offered no systematic assessment of quality and Volkert et al. (2013) included only three articles reporting prevalence rates of PTSD. As such, there remains a need for the present literature pertaining to the prevalence of PTSD in older people to be subjected to a review of its quality and the findings summarised.

Methods

Preliminary Search Strategy

A preliminary search was conducted in December 2012 using the following databases: MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINHAL), psycINFO, PsychARTICLES, Excerpta Medica Database Guide (EMBASE), and Published International Literature on Traumatic Stress (PILOTS). The terms used to conduct the search were *posttraumatic stress disorder* or *anxiety disorder;* and *geriatric* or *elderly* or *older adult;* and *prevalence* or *epidemiology*. The search yielded just over 2000 studies with considerable numbers of irrelevant and duplicated articles, which was out with the scope of this review. Key terms from relevant articles were identified to inform the search terms utilised in the second search.

Principal Search Strategy

The following databases were searched in week 27 of 2013 to identify relevant studies: OVID electronic database EMBASE, MEDLINE, psycINFO. The following terms were combined in the search: *posttraumatic stress disorder* or *post-traumatic stress disorder;* and *elderly* or *"late life"* or *"old age"* or *geriatric;* and *prevalence* or *epidemiology*. The search

was limited to articles published since 2000 and written in the English language. This search yielded 174 studies, which reduced to 135 when duplicates were removed.

Titles and abstracts were manually searched to determine relevance of the studies. Where there was doubt regarding relevance of a study, the methods and results from the full text article were read.

Search of Reference Lists and Web of Science

Two studies referenced companion articles in their methodology. The reference lists of all included articles, and their companion articles were searched for relevant studies. Additionally, all articles which met inclusion criteria were entered into Web of Science and Google Scholar to identify relevant studies which may have since cited those included.

Inclusion and Exclusion Criteria

Studies were included in the review if they reported the prevalence of PTSD in community samples of older people. It is recognised that irrespective of its arbitrary nature, 65 years of age is routinely the threshold for entry into older peoples' services, and therefore ideally, this definition would have been used in the current review. However, the limited number of studies using this definition meant that for the purpose of this review, older people were considered those over 60 years of age

In order to be included, studies required to have used DSM-III, DSM-IV or International Classification of Diseases (ICD-10: WHO) criteria for diagnosing PTSD. Current, or twelve month prevalence must have been reported and studies reporting lifetime prevalence only were excluded. Studies reporting on samples of specific groups, such as veterans, residential or nursing homes and geographical areas which had experienced natural disasters were excluded, as they are not representative of a community population.

Only studies which sampled participants from western countries (Europe, Australia, New Zealand and North America) were included in the review, as these are considered to be comparable (Kessler et al., 2010). Reviews not published in English were excluded as translation was unfeasible.

Where more than one study reported results based on the same data, the article considered to be most relevant was included. In order to provide information relating to two cohorts (Knight, 2004), only studies whose participants were recruited since 1993 were included.

Quality Criteria

Criteria for assessing the quality of studies are outlined in Table 1. These quality criteria were adapted from Boyle (1998) 'Guidelines for evaluating prevalence studies'. A decision was taken not to use summary scores to differentiate between high and low quality studies based on the recommendation by the Centre for Reviews and Dissemination (2009). Each included study was rated according to the quality criteria by the author and half were second rated by a trainee clinical psychologist. Agreement between reviewers was 96.4%.

Table 1. Framework for assessing the methodological quality of studies

	Quality criteria	**Description**	**Categorisation**
Sampling	Target population clearly defined	Inclusion and exclusion criteria clearly defined	Yes / No
	Method of sampling	Random sampling well reported and obtained through means likely to be representative of target population (population register / multiple data sources)	Well covered
		Stratified or cluster sampling used and well described	Adequately addressed
		Random sampling from source of data unlikely to be representative of target population OR stratified or cluster sampling used and not clearly reported	Limited

		Limited information on how sample were recruited	Not addressed
	Sample representative of defined target population	Sample characteristics are reported and compared to non-respondents and national statistics	Well covered
		Sample characteristics are reported and compared to either non-respondents or to national statistics	Adequately addressed
		Sample characteristics are reported, however no comparisons are made	Limited
		Limited or no sample characteristics are reported	Not addressed
Measurement	Standardised collection methods	Trained interviewer with supervision	Well covered
		Trained interviewer without supervision	Adequately addressed
		Untrained interviewer or self-report	Limited
		Not reported	Not addressed
	Measures used have established reliability and validity	All measures have reported evidence of acceptable reliability and validity for older people	Well covered
		More than 50% measures are validated for older adults OR all measures have reported evidence of reliability and validity for adults	Adequately addressed
		Less than 50% of measures have reported evidence of reliability and validity for adults or older adults	Limited
		Reliability and validity of measures not reported	Not addressed
Analysis	Features of the sampling design accounted for in analysis	Sampling design accounted for and clearly reported	Well covered
		Sampling design accounted for in majority of analysis	Adequately addressed
		Sampling design accounted for but poorly reported	Limited
		Sampling design not discussed or not accounted for	Not addressed

	Power	Estimation of power reported and achieved	Well covered
		Estimation of power reported but not achieved	Limited
		No estimation of power reported	Not addressed

Data extraction

The following data were extracted from the included articles: authors names, publication year, country and year of data collection, inclusion and exclusion criteria, definition of old age, mean age of 'elderly' sample, gender distribution, sample size and response rate, diagnostic criteria, exposure to traumatic events, prevalence type and rate, instruments used, and any additional relevant findings.

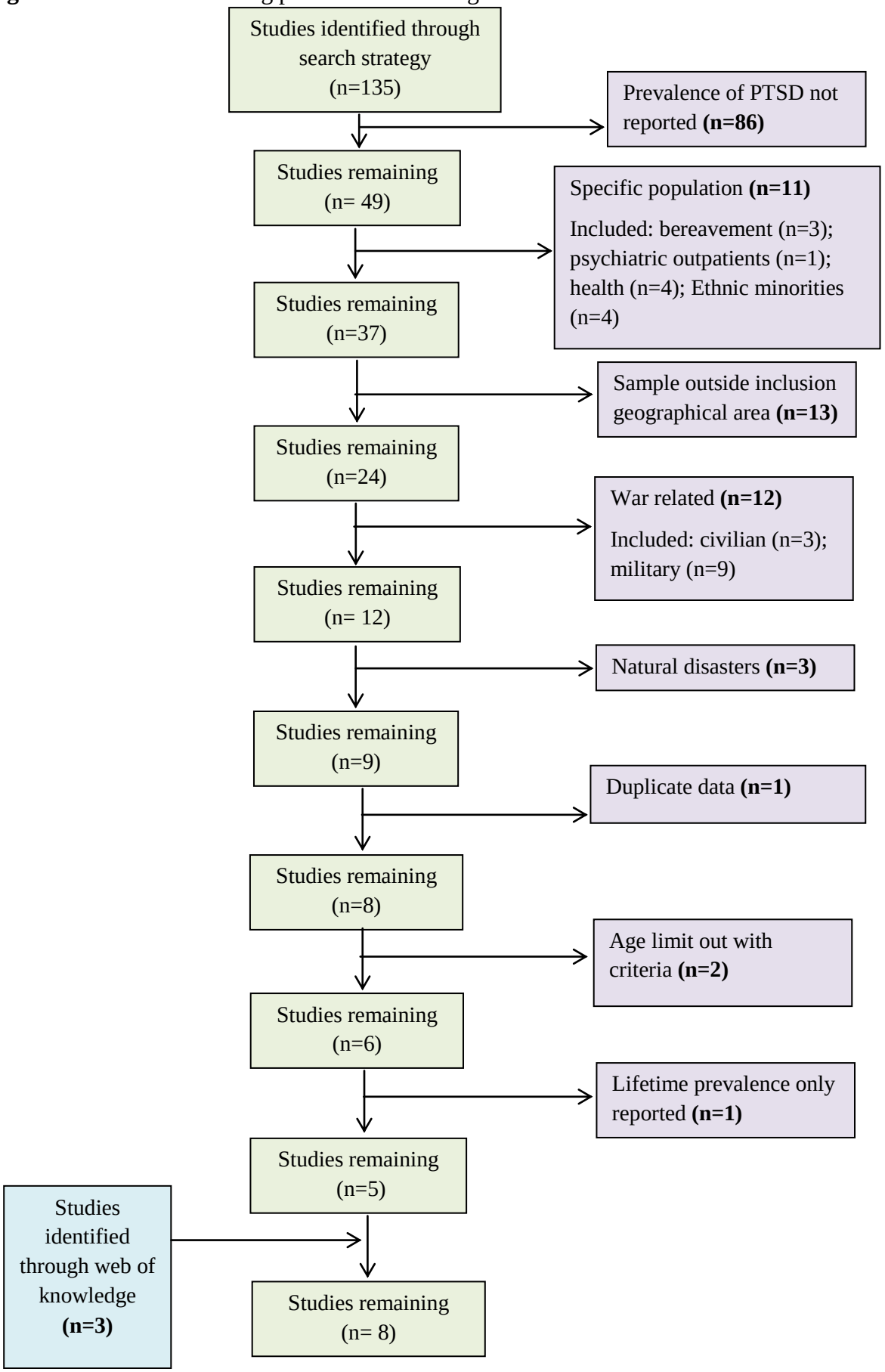
Results

Study Inclusion

The search strategy identified a total of 135 articles. The process of eliminating articles from the review is summarised in Figure 1. A total of eight studies met inclusion criteria, three of which were identified through Web of Science and the reference lists of other included articles.

One of the identified studies (Van Ameringen, Mancini, Patterson, & Boyle, 2008) provided demographic information for people over the age of 65, however did not report prevalence rates for this group. The authors were contacted and the data retrieved in this way.

Figure 1. Flowchart detailing process of excluding studies from review



General Characteristics of Included Studies

The key general characteristics of the studies included are summarised in Table 2. Two of the reviewed studies sampled only older people (Chaudieu et al., 2011; Maercker et al., 2008). The remaining six reported prevalence rates of older people, but sampled across the adult age range. Glaesmer, Gunzelmann, Braehler, Forstmeier and Maercker (2010) and Glaesmer, Kaiser, Braehler, Freyberger, and Kuwert (2012) defined older people as over the age of 60 years whilst the remaining defined it as over 65 years. Only one study included people with cognitive impairment (a Mini Mental State Examination score of <23 was an exclusion criteria) and older people living in residential care, which amounted to 3.2% of the sample (Spitzer et al., 2008).

Data were collected between the years of 1997 and 2008. Seven studies used cluster or stratified sampling, with information gathered from: a population register (Spitzer et al., 2008), telephone registry (Van Ameringen et al., 2008), resident's register (Maercker et al., 2008), census data (Gum, King-Kallimanis, & Kohn, 2009), unclear (Creamer & Parslow, 2008; Glaesmer et al., 2010; Glaesmer et al., 2012); and the study conducted in France randomly sampled from electoral roles (Chaudieu et al., 2011). Although two studies were longitudinal in design, the data presented by Chaudieu et al. (2011) represented baseline and Spitzer et al. (2008) obtained the data at only one time point. The remaining studies were cross-sectional in design. Sample sizes ranged from 508 to 1792 participants with response rates between 60.9% and 80%, with one study not reporting response rate.

Where reported, the average age of participants was between 69.9 and 74 years, however five of the studies did not provide an average age of the older people in the sample. As would be expected given that women live longer (Kinsella & Velkoff, 2001), in all studies, women

outnumbered men. The gender difference was only found to be statistically significant in one study (Spitzer et al., 2008).

Four studies utilised the same instrument to ascertain exposure to traumatic events and assess for PTSD. The three measures used in this way were: the Composite International Diagnostic Interview (CIDI: Kessler & Ustun, 2004); a modified version of this which replaced questions about childhood abuse with experience of 'torture or terrorism' (Andrews & Peters, 1998); the Structured Clinical Interview for DSM-IV (SCID: First, Spitzer, Gibbon, & Williams, 1997), adjusted to ask directly about exposure to events included as traumas in DSM-IV, including sudden and unexpected death of a loved one; and the Watson PTSD Inventory (PTSD-I: Watson, 1991).

The remaining four studies measured exposure to traumatic events and PTSD symptomology using separate instruments. Three measures were employed to assess exposure to traumatic events: the Traumatic Events Checklist of the Munich-CIDI (Wittchen & Pfister, 1997); the Canadian Community Health Survey (CCHS: Statistics Canada, 2004) and sections of the Childhood Trauma Questionnaire (CTQ: Bernstein & Fink, 1998).

The remaining three studies utilised the following measures to assess for PTSD: the Short Screening Scale for DSM-IV PTSD (Breslau, 1999); the PTSD Symptom Scale (PSS: Foa, Riggs, Dancu, & Rothbaum, 1993); and the Canadian Community Health Survey (CCHS: Statistics Canada, 2004).

Four studies provided data on either partial or sub-syndromal PTSD (sPTSD: Creamer & Parslow, 2008; Glaesmer et al., 2010; Glaesmer et al., 2012; Maercker et al., 2008).

Table 2. General characteristics of included studies

Author/ Country/ year data collected	Sampling / Design	Inclusion / exclusion criteria	Sample size / definition of OA / sample characteristics	Diagnostic criteria PTSD (partial or sPTSD)	Measures used	Exposure to traumatic events	Prevalence type and rate (partial or sPTSD)	Other relevant findings
Chaudieu et al. (2011) / France / 99-01	Random selection from electoral rolls Longitudinal, current data is baseline	Community dwelling; over 65 years; excluded dementia	1662 (72.7% response rate) / Over 65 years / Average age: 72.5/ 59% female, 41% male Other demographics of whole sample not reported	DSM-IV	PTSD – I (exposure and prevalence); MINI (other axis 1); CESDS (depression); MMSE (cognitive functioning)	Total: 55.9% Female: 53.7% Male: 59.3% War related (52.9%); Unexpected death of a loved one (20.3%) Accident of loved one (8.0%); Interview median of 54.6 years after event	*1 month* Total: 1.2% Female: 2.0% Male: 0.2% (p=0.02)* *Lifetime* Total: 2.4% Female: 3.8% Male: 0.4% (p=0.001)*	Current PTSD and current MDD: 6.56%; current depressive symptoms: 38.82%; at least 1 current anxious disorder: 20.66%; lifetime suicide attempt: 7.47%
Creamer & Parslow (2008) / Australia / 1997	Households selected, person with next birthday asked to participate Cross-sectional	Community dwelling; 18+	1792 (78% response rate) Over 65 years Average age: not reported	DSM-IV (sPTSD - re-experiencing only)	Modified CIDI (exposure and prevalence)	Total: 52.5% Female: 40.8% Male: 69.5%	*12 month* Total: 0.2% (10%) Female: 0.0% (8.6%) Male: 0.4% (11.6%)	None
Glaesmer et al. (2010) / Germany / 2005	Stratified by area, households selected randomly Cross-sectional	Community dwelling; age 14 yrs +; read and understand German	814 (60.9% response rate) Over 60 years Average age: 69.6	DSM-IV; (Partial I – at least 2 symptoms from clusters B,C, D and F fulfilled) (Partial II- at least 2	Munich- CIDI (exposure) ;Short Screening Scale for PTSD (prevalence)	Female: 54.4% Male: 45.6% War related – Female/ Male (56.0% / 44.0%); serious accident – Female / Male (3.7% /8.2%); physical violence – Female / Male (5.1% / 12.9%); life	1 month: Total: 3.4% Partial I: 1.0% Partial II: 2.8%	Avoidance of thoughts & feelings most common symptom cluster (25%), followed by sleep disturbances, recurrent intrusive thoughts and exaggerated startle response (no differences across age range in sample)

				symptoms from clusters B, C, D, not F)		threatening illness Female / Male (4.0% / 7.6%)		
Glaesmer et al. (2012) / Germany / 2008	Stratified by area, households selected randomly	Community dwelling; age 14 yrs +; read and understand German	1659 (62.1% response rate) Over 60 years Average age: not reported	DSM-IV Partial I – A and at least 1 symptom from at least 2 of B,C,D	Munich- CIDI (exposure); PSS (prevalence); PHQ-9 (somatoform, depression)	No total or sex reported	1 month: Total: 4.0% (7.5%) Female: 4.1% (7.9%) Male: 4.0% (7.1%) 60-64: 3.3% 65-69: 3.2% 70-74: 4.7% 75-79: 4.0% 80-85: 6.6% (p-0.078)	All PTSD symptomology* with co-morbid somatoform syndrome (11.5%); MDD (8.6%) other depressive syndrome (10.4%)
Gum et al. (2009) / USA / 2001-2003	Stratified sampling from census data Cross sectional	Community dwelling, 18 years +; English speaking	1461 (70.9% response rate) Over 65 years Average age: 74 Female: 57.7% Male: 42.3% 82.9% non-latino white	DSM-IV	CIDI (exposure and prevalence)	Not reported	*12 month* Total: 0.4% Female: 0.5% Male: 0.3% 65-74: 0.6% 75+: 0.2% Lifetime: Total: 1.6% Female: 2.5% Male: 0.4% 65-74: 2.1% 75+: 1.1%	None
Maercker et al. (2008) / Switzerland / not reported	Stratified from resident's registration office Cross sectional	65-96 years; Included elderly institution; excluded suspected dementia	570 (80% response rate) Over 65 years Average age: 74 Female: 58.1%	DSM-IV sPTSD – no clear definition provided	Munich – CIDI (exposure); Short screening scale for DSM-IV (prevalence)	Total: 36.3% Severe accidents (12.5%); physical threats (11.1%); war related (8.4%)	1 month Total: 0.7% Female: 0.9% Male: 0.4% (p=0.64)	No sex or age differences

			Male: 41.9%				sPTSD Total: 4.2% Female: 5.2% Male: 2.9% (p=0.21)	
Spitzer et al. (2008) / Germany / 2002-2006	Random sample from population register Longitudinal study, included data cross-sectional	German citizenship; 20-79 years MMSE <23 3.2% residential home	851 (response rate not reported) Over 65 years; Average age: not reported	DSM-IV	SCID-I (Exposure and prevalence); MMSE; CID-S	Total: 54.6% Sudden unexpected death of loved one (41.7); combat / war zone experience (39.7%)	1 month Total: 1.5% Female: 2.4% Male: 0.8% (p= 0.107) (CI: 0.09-1.42) Lifetime Total: 3.1% Female: 4.1% Male:2.2% (p= 0.167) (CI: 0.21-1.30)	Lifetime PTSD and 12 month prevalence of depression (70%); anxiety syndromes (65%)
Van Ameringen et al. (2008) / Canada / 2002	Random digit dialling (97% Canadians owned telephone in 2001)	Community sample 18+	508 (68.1%) Over 65 years Average age: Not reported	DSM-IV	Sections of CTQ (exposure); CCHS (exposure and prevalence);	Data not available for age group	1 month: 0.8%. Lifetime= 3.3%	None

Key: CIDI: the Composite International Diagnostic Interview (Kessler & Ustun, 2004); SCID: the Structured Clinical Interview for DSM-IV (First et al., 1997); PTSD-I: The Watson PTSD Inventory (Watson, 1991); CCHS: Canadian Community Health Survey (Statistics Canada, 2004); CTQ: the Childhood Trauma Questionnaire (Bernstein & Fink, 1998); PSS: PTSD Symptom Scale (Foa & Riggs, 1993); MINI: Mini-International Neuropsychiatric Interview(Sheehan et al., 1998); CESDS: Center for Epidemiological Studies Depression Scale; MMSE: Mini Mental State Examination (Folstein, Folstein, & McHugh, 1975); PHQ-D: the Patient Health Questionnaire – German version (Loewe, Spitzer, Zipfel, Herzog, 2002); MDD: Major depressive disorder; CIDS-S: Composite International Diagnostic-Screener (Wittchen et al., 1999); * significant difference.

Table 3. Summary of methodological quality of reviewed studies

	Quality criteria						
Studies	**Target population defined**	**Method of sampling**	**Sample demographics reported**	**Standardised collection methods**	**Reliable and valid measures**	**Design accounted for in analysis**	**Power**
Chaudieu et al. (2010)	Yes	Limited	Adequately addressed	Limited	Adequately addressed	Well covered	Not addressed
Creamer & Parslow (2008)*	Yes	Limited	Limited	Adequately addressed	Not addressed	Well covered	Not addressed
Glaesmer et al. (2010)	Yes	Adequately addressed	Limited	Limited	Adequately addressed	Well covered	Not addressed
Glaesmer et al. (2012)	Yes	Adequately addressed	Limited	Limited	Limited	Well covered	Not addressed
Gum et al. (2009)**	Yes	Adequately addressed	Well covered	Well covered	Adequately addressed	Well covered	Not addressed
Maercker et al. 2008	Yes	Adequately addressed	Adequately addressed	Limited	Limited	Well covered	Not addressed
Spitzer et al. (2008)	Yes	Well covered	Adequately addressed	Limited	Limited	Well covered	Not addressed
Van Ameringen et al. (2008)	Yes	Well covered	Adequately addressed	Adequately addressed	Adequately addressed	Well covered	Not addressed

*(Creamer, Burgess, & McFarlane, 2001) ; ** (Kessler, 2004)

Exposure to Traumatic Events

In the four studies where it was reported, total exposure ranged from 36.3% (Maercker et al., 2008) to 55.9% (Chaudieu et al., 2011), with the former being somewhat of an outlier as the next closest prevalence rate reported was 52.5% (Creamer & Parslow, 2008). In considering this finding in more detail, only 8.4% of Maercker et al.'s (2008) sample had experienced war related trauma which contrasts markedly with other studies and perhaps can be explained by this study having been conducted in Switzerland. Chaudieu et al. (2011) used the Watson PTSD inventory, based on DSM-III-R criteria which links the traumatic event to a normative objective standard, whereas DSM-IV, utilised by all other included studies, considers the individual's subjective standard of the emotional response. Interestingly, despite this more restrictive criterion, this study reported the highest rates of exposure.

In two studies, exposure to combat or war related trauma were the most common, 52.9% (Chaudieu et al., 2011) and 54.4% (Glaesmer et al., 2010). Spitzer et al. (2008) found the sudden unexpected death of a loved one to be the most prevalent trauma experience (41.7%), although it is possible that this is a function of the emphasis placed on this item in the instrument employed. The same item which did not appear to be stressed so strongly in the measure was endorsed by 20.3% of the French sample (Chaudieu et al., 2011). The second most common trauma events reported by Maercker et al. (2008) was severe accidents (12.5%), followed by physical threats (11.1%).

Among the four studies reporting separate rates of exposure for men and women, only Glaesmer et al. (2010) found women to have had greater exposure to traumatic events than men (54.4% and 45.6% respectively). Unusually, in this study, women reported higher rates of war related trauma. Creamer and Parslow (2008) and Chaudieu et al. (2011) found exposure to trauma events among women of 40.8% and 53.7% respectively, and among men

59.3% and 69.5% respectively. The significance of these differences was not reported. Using logistic regression, Creamer and Parslow (2008) found negative association with age square (Wald statistic = 51.43, OR = 0.93, CI: 0.91-0.95, df = 1, $p < 0.01$), however among men, trauma exposure was positively associated with age (Wald statistic = 5.03, OR = 1.24, CI: 1.03-1.50, df = 1, $p = 0.03$). The authors suggest this phenomenon is best explained by combat exposure, as 28% of men had experienced combat in comparison to only 2% of women (all other combined traumas experiences came to 41% for men and 38% for women). Spitzer et al. (2008) reported women to have had significantly fewer instances of lifetime exposure to traumatic events than men (men: 2.3 +/- 1.3; women: 1.7 +/- 1.0, $p<0.001$).

Current (One Month) Prevalence of PTSD

Six studies report one month prevalence rates which range from 0.7% (Maercker et al., 2008) to 4.0% (Glaesmer et al., 2012). The most methodologically sound study reporting one month prevalence (Van Ameringen et al., 2008) found a rate of 1.5%, and similar findings were reported by Chaudieu et al. (2011: 1.2%), and Spitzer et al. (2008: 1.5%). The low rates reported by Maercker et al. (2008) are in keeping with their findings of lower exposure to trauma events.

Two studies conducted by Glaesmer et al. (2010) and Glaesmer et al. (2012) found similar rates of prevalence 3.4% and 4.0% despite using different measures. A possible contributory factor in the higher rates reported in these studies is the definition of older people as over 60 years, compared with other studies which use 65 years as the threshold. Therefore one might expect slightly higher prevalence rates in these studies, as evidence consistently suggests younger groups have higher prevalence of PTSD (Kessler et al., 2005; Pietrzak, Goldstein, Southwick, & Grant, 2011).

Significant differences in prevalence were found between men and women by Chaudieu et al. (2011), who found rates of 0.2% and 2.0% respectively (p=0.001), despite women endorsing exposure to fewer traumatic events than men. The two other studies reporting this data, (Glaesmer et al., 2012; Spitzer et al., 2008) indicate no significant differences, although Sptizer et al. (2008) found 2.4% prevalence in women and 0.8% in men.

As discussed above, Chaudieu et al.'s (2011) use of the Watson PTSD inventory, based upon DSM-III-R criteria may limit diagnostic sensitivity, as those who subjectively experienced an event as traumatic may not meet objective criteria. It is possible therefore that this study under-reports the prevalence rate.

Glaesmer et al. (2012) report one month prevalence by age group (Table 2). The prevalence of PTSD in the 80-85 age group (6.6%) is double that found in the 65-69 group (3.2%) which the authors attribute to the effect of war related trauma.

Twelve Month Prevalence of PTSD

Similar prevalence rates were found in the two studies which report twelve month prevalence of PTSD. Creamer and Parslow (2008) found a total rate of 0.2% whilst Gum et al. (2009), one of the most methodologically sound studies included, reports 0.4%. No significant difference is reported in relation to gender in either study. Gum et al. (2009) provide a breakdown according to age groups and report twelve month prevalence of 0.6% amongst those aged between 65 and 74, and 0.2% in those over the age of 75. These findings contrast with Glaesmer et al. (2012), summarised above who found one month prevalence increased with age. This difference arguably supports Glaesmer et al.'s (2012) hypothesis of higher prevalence in older people being a function of the war in Germany.

Lifetime Prevalence of PTSD

Lifetime prevalence was reported by four of the reviewed studies. Gum et al. (2009) report total rates of 1.6%, Chaudieu et al. (2011) report lifetime prevalence of 2.4%, whilst Spitzer et al. (2008) and Van Ameringen et al. (2008) report rates of 3.1%. A consistent finding was higher rates of PTSD in women than men. Chaudieu et al. (2011) found a significant difference between men and women (0.4% and 3.8% respectively: p=0.001). Spitzer et al. (2008) report 4.1% among women and 2.2% among men, despite men having higher exposure. The difference however was not found to be significant. Gum et al. (2009) report lifetime prevalence of 0.4% in men and 2.5% in women which was not tested for significance.

Gum et al. (2009) broke down lifetime prevalence according to age groups, again demonstrating a reduction of prevalence with age, as those between the age of 65 and74 years had lifetime prevalence of 2.1% and those over 75 a lifetime prevalence of 1.1%.

Comorbid conditions

Depression.

Current depression as assessed by CEDS and MINI (French version) was found to be present in 6.56% of those with current PTSD by Chaudieu et al. (2011). Glaesmer et al. (2012) correlated all PTSD symptomology, which was broadly defined, with major depressive disorder (MDD) and found comorbidity of 8.6%. Lifetime PTSD and twelve month depression was found to be 70% (Spitzer et al., 2008). Chaudieu et al. (2011) report that of those with lifetime experience of PTSD, 7.47% reported having attempted suicide.

Anxiety.

Anxiety disorders were found to be co-morbid with current PTSD in 20.66% of cases (Chaudieu et al., 2011). Amongst those respondents who reported lifetime PTSD, Spitzer et al. (2008) found twelve month prevalence of anxiety syndromes in 65%.

Somatoform syndrome.

Glaesmer et al. (2012) found all PTSD symptomology was comorbid with somatoform syndrome 11.5% of the time.

Partial or sub-syndromal PTSD

The lack of a single accepted definition of partial or sPTSD is reflected in the studies reviewed. Each study utilised a different definition making conclusions hard to draw. Based on anecdotal evidence that re-experiencing symptoms increases with age, Creamer and Parslow (2008) investigated the prevalence of those only meeting criteria B (re-experiencing symptoms). They found that the total twelve month prevalence was 10%, 11.6% among men and 8.6% among women.

Glaesmer et al. (2010) used two definitions (which met criteria A): Partial I – at least two symptoms from clusters B, C, D and F fulfilled; and Partial II- at least two symptoms from clusters B, C, D, not F. Their 2010 study reports current prevalence of 1.0% for partial I and 2.8% for partial II. Glaesmer et al. (2012) using the same definition, report significantly higher rates of current partial I PTSD (7.5%). They attribute this difference to the use of a more comprehensive measure in the 2012 study (PTDS).

Maercker et al. (2008) report rates of sPTSD, however it was hard to establish from the article what definition was utilised. They report a total one month prevalence rate of 4.2% based upon the Short Screening Scale for DSM-IV

Methodological Considerations of the Studies

The findings of this review must be interpreted in the context of methodological considerations of the included studies. All of the reviewed studies offered a clear description of their target population. A range of information sources were used to identify participants across the studies. The population register utilised by Spitzer et al. (2008) is likely to return a representative sample. Contrastingly, sampling from electoral roles (Chaudieu et al., 2011) introduces bias to those most likely to be registered to vote. Demographic characteristics of the sample were not compared to those who did not participate or national demographics, introducing the question of how generalisable the results are. The studies by Glaesmer et al. (2010) and Glaesmer et al. (2012) both report little information regarding the source of their sample information and did not compare their sample characteristics with non-responders or national statistics, which again calls into question the generalisability of their findings.

Three of the reviewed studies (Maercker et al., 2008; Spitzer et al., 2008; Van Ameringen et al., 2008) reported demographics of the sample and offered comparisons to national statistics or non-responders. Differences were found in terms of the age of men and women, with women being significantly younger than men in one study, in which the reported difference was accounted for in the analysis, reducing the likelihood of bias (Spitzer et al., 2008). Maercker et al. (2008) report the sample utilised in the relevant phase of the study being younger, included more men, and contained more persons who lived with partners than those who dropped out, allowing potential bias to be recognised. A significantly larger number of males were sampled by Van Ameringen et al. (2008) which was accounted for in the analysis. One study compared sample characteristics to both non-respondents and population demographics (Gum et al., 2009), in which the authors acknowledge that 82.9% of their sample were non-Hispanic, white and therefore not representative of the wider population. With the exception of two studies (Chaudieu et al., 2011; Maercker et al., 2008) the reviewed

studies sampled across age groups, and no specific comparison of the older population to national statistics was made.

All reviewed studies provided clear descriptions of how sampling was considered within the statistical analysis, however none provided an estimate of statistical power or reported whether power was likely to have been achieved. The majority appeared to have large sample sizes, however, studies with smaller numbers which further categorised age groups may have resulted in some aspects of their analysis being underpowered.

None of the articles, including those sampling only older people report validity or reliability of the measures with regard to older people. Evidence suggests that cohort effects may influence how older people conceptualise their difficulties and their familiarity with the language routinely used in mental health assessments (Knight, 2004). Furthermore, comorbidity with physical health problems can confound assessments and indeed, Jorm (2000) noted that measures including the CIDI may discount symptoms that may be attributable to physical health problems. These factors together suggest making the assumption that these instruments would be equally valid and reliable with older people as with adults of working age is misguided.

In total five studies (Chaudieu et al., 2011; Glaesmer et al., 2010; Maercker et al., 2008; Van Ameringen et al., 2008) provided reliability and validity statistics for the measures employed, whilst three did so for 50% or fewer of the measures, calling into question the validity and reliability of their findings (Creamer & Parslow, 2008; Glaesmer et al., 2010; Spitzer et al., 2008).

In the current review, five studies utilised self-report measures in their assessment of PTSD (Chaudieu et al., 2011; Glaesmer et al., 2010; Glaesmer et al., 2012; Maercker et al., 2008; Spitzer et al., 2008), which introduce greater potential for bias. Beck and Averill (2000)

suggest that self-report measures are more likely to underestimate prevalence rates than diagnostic interviews. Where studies used diagnostic interviews, only Gum et al. (2009) reported the training and on-going supervision of interviewers, the remaining two studies reported training for interviewers, but not supervision, introducing the potential for researcher bias.

Discussion

The findings of this review suggest that between 36.3% and 55.9% of older people have been exposed to at least one traumatic event during their lifetime. War related experiences appear to account for the majority of the differences in exposure to traumatic events in the western world, however the heterogeneous nature of the measures and criteria, make drawing comparisons across the studies less meaningful. Other traumatic events which were prevalent included serious accidents, the sudden death of a loved one, life threatening illness and physical threats. With the exception of one study, men were found to have been exposed to more traumatic events than women.

Although current prevalence rates of PTSD were found to be between 0.7% and 4.0%, these two figures represent outliers, based on samples with both lower and higher exposure to traumatic war events. Three of the five studies reported similar prevalence rates of 1.5%, and 1.2% which are consistent with the overall random-effects estimate found by Volkert et al. (2013) for current PTSD (1.68%: 95% CI, 1.00–2.36%) in their meta-analysis. The two studies reporting twelve month prevalence of PTSD report similar rates of 0.2% (Spitzer et al., 2008), and 0.4% (Gum et al., 2009). Lifetime prevalence rates of PTSD between 1.6% and 3.1% were reported by four of the reviewed studies. This is consistent with Volkert et al.'s (2013) finding of 2.5% (95% CI, 1.49–3.53%) for lifetime PTSD. These findings

suggest the twelve month and lifetime prevalence of PTSD in older people is less than is found in adults of working age. Creamer et al. (2001) report estimated twelve month prevalence across the age ranges of 1.33% in Australia, notably lower than those found by Kessler (2005b) in the United States, 3.5%. Kessler et al. (2005a) report lifetime DSM-IV PTSD prevalence of 6.8% in younger adults, and similarly, Pietrzak et al. (2011) report lifetime prevalence of 6.4%.

Despite less exposure to traumatic events, the prevalence of PTSD in women was found to be consistently higher, although a significant difference was only found in one study. This is consistent with findings among younger cohorts (Kessler et al., 2005a; Pietrzak et al., 2011). Although Hapke (2006) suggests that factors such as pre-morbid anxiety and sexually related trauma events among women explain this difference, others argue that while these factors go some way to explaining the difference, they do not account for the full variation (Pietrzak et al., 2011).

Contrasting findings were reported in the two studies which broke the sample down further according to age. A German based study (Glaesmer et al., 2012) found prevalence of current PTSD increased from 3.2% at the age of 65, doubling to 6.6% for those aged between 80 and 85 years. However, Gum et al. (2009), in their American based study, not only found lower rates overall, but lower twelve month and lifetime prevalence rates amongst over 75s than those aged 65 to 74 (1.1% and 2.1% respectively). It seems likely that this difference can be accounted for by the wartime experiences of older people living in Germany.

The different definitions of partial or sub-syndromal PTSD, the different time frames over which prevalence was assessed and methodological differences between studies, limits the extent to which conclusions can be drawn and provides context for the broad range of results. Current prevalence of partial PTSD ranged from 1.0% to 10% in the reviewed studies.

Glaesmer et al. (2012) consider the results of 1.0% found in their 2010 study to be a function of the brief measure utilised. If this is discounted, the remaining articles report rates of 7.5% and 10%. These figures are more consistent with the lifetime prevalence of partial PTSD in people over 65 years of 6.6% reported by Pietrzak et al. (2012), using the definition provided in the introduction. These relatively high rates of partial PTSD are relevant as evidence is accumulating to suggest that partial PTSD can persist for years (Jeon et al., 2007; Schnurr et al., 2003). Furthermore, it has been found to be associated with worse levels of general functioning, co-morbid depression and greater utilisation of health services in comparison to a control group without PTSD (van Zelst, 2006).

This review did not set out to investigate conditions which are comorbid with PTSD, however briefly summarised the findings of those studies included within the review. Major depressive disorder was found to be co-morbid with PTSD in 8.6% and 6.56% cases, and comorbid with anxiety disorders in 20.66% of cases. The use of current and lifetime PTSD and sub-syndromal PTSD prevalence rates in the analyses render comparisons less meaningful, however these preliminary findings highlight the range of factors which need further investigation.

A number of explanations are postulated for the lower levels of PTSD found in older people compared with adults of working age. First, the length of time since the trauma leads some to suggest recall bias is operational, that the perceived salience of events lessen over time or are re-appraised (Creamer & Parslow, 2008). Second, it is argued that as PTSD contributes to physical ill health, it results in premature mortality (Acierno et al., 2001; Schnurr & Green, 2004), or that a large proportion of those with PTSD are in residential or nursing homes (Cook & O'Donnell, 2005) and consequently non-traumatised respondents are over represented in older populations. Third, Owens et al. (2005) suggest that older people may attribute their symptoms to ageing or physical ill health and therefore not offer responses to

questions regarding these symptoms. Fourth, the inoculation hypothesis proposes old age to be a protective factor, with people having developed coping skills, possibly having experienced trauma in the past, such that they experience less distress in later life (Eysenck, 1983). Last, cohort effects have been shown to result in a tendency for older people to under-report psychological symptoms (Cook et al., 2006).

Since it's inclusion in DSM-III in 1980, the diagnostic criteria for PTSD have been subject to much debate and numerous revisions. One area of debate and change has been the definition of stressors which qualify individuals for the disorder (criterion A). In DSM-III the stressor was described as an event likely to evoke significant symptoms in almost anyone, this was revised in DSM-III-R to an event outside the normal range of experience. DSM-IV criterion was more specific about the stressor being a threat to the individual, a family or friend's physical integrity and stipulated a further criterion of the individual's response involving helplessness or horror. The latter has been removed in DSM-V as no evidence for its diagnostic utility was found. DSM-IV added criterion F, specifying that individuals must experience significant levels of distress or impairment, which resulted in a decrease in prevalence rates from DSM-III (Van Ameringen et al., 2011).

Furthermore, successive editions of DSM have increased the number of symptoms described in the criteria. DSM-V saw the addition of a cluster of symptoms which relate to persistent changes in mood and cognition to include anger, shame and guilt and a dissociative sub-type of PTSD. These recent changes offer recognition of the heterogeneity of responses to trauma events and may result in greater numbers of people meeting diagnostic criteria. All but one study in this review (Chaudeiu et al., 2011) utilised the DSM-IV criteria. It is possible therefore that future research into prevalence using DSM-V criteria may find higher rates than this review summarises for older people, potentially capturing some of those who presently fall in the sub-syndromal category.

This review has a number of limitations which must be considered in relation to the findings. A number of databases were excluded from the primary search, introducing the possibility that not all relevant articles were identified. The risk of this was reduced by the preliminary search of numerous databases in which no other relevant studies were identified. The exclusion of studies not written in English introduces the potential for culture bias, however, the inclusion of five studies conducted in countries where English is not the first language suggests this is less likely. The relatively small number of studies which met the inclusion criteria, heterogeneity of measures and definitions make the comparisons drawn between studies less meaningful.

Implications for Future Research and Clinical Practice

There is need for longitudinal studies in this area which would provide valuable information regarding the course, mediators, presentation and comorbidities of PTSD and partial PTSD in older people. Wider use of measures validated on this population would enable clinicians to have greater confidence in the findings and provide guidance on the assessment of the condition.

As the UK population is ageing, it is projected that the greatest rises will be in the numbers of those aged 85 and over (ONS, 2012). The reported average age of participants in this review were between 69.9 and 74 years, suggesting there remains a paucity of research into the oldest old which needs to be urgently addressed.

Whilst the current prevalence of PTSD in older people seems to be relatively low, perhaps of greater concern are the rates of partial PTSD. Clinicians should ensure comprehensive

assessments are conducted to identify both PTSD and partial PTSD and interventions provided accordingly.

Conclusions

The available evidence suggests between 36.3% and 55.9% of older people will be exposed to at least one traumatic event in their lifetime, with war related experiences seemingly accounting a large proportion of the difference. Current prevalence was found to range between 0.7% and 4.0%, twelve month prevalence rate of 0.2% and 0.4% were reported while lifetime prevalence rates of PTSD were between 1.6% and 3.1%. Subsyndromal or partial PTSD ranged from 1.0% to 10%, with methodological differences and varying definitions accounting for this heterogeneity. Comparisons between the studies are made less meaningful by two definitions of older adults, different criteria used to assess PTSD and methodological limitations.

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CHAPTER TWO

JOURNAL ARTICLE

PTSD in Older People: Factors influencing clinical decision making in psychological therapy.

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Running head: Clinical decision making relating to PTSD in older people

Abstract

The evidence regarding posttraumatic stress symptomology in older people is limited and conflicting, leaving clinicians largely reliant on their expertise to make clinical decisions. Grounded theory methodology was utilised to investigate clinical decision making in this context. Semi-structured interviews were conducted with eight clinical psychologists with experience of this work. 'Balancing complexity, resources and demand' emerged as the main theoretical category, comprised of seven further subcategories. The model is broadly consistent with extant literature pertaining to the adaptation of psychological therapy for older people, offering further detail on implementation and the influence of treatment non-specific factors.

Keywords: Older people; posttraumatic stress disorder; clinical decision making; qualitative methods

Word count: 10,132

1. Introduction

There is increasing pressure on services to deliver evidence-based interventions to all client groups. The American Psychological Association (APA Presidential Task Force on Evidence-Based Practice, 2006, p.273.) defines evidence-based practice in psychology as: "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences". They go on to acknowledge that there are many mental health conditions for which there is only scant evidence. In such instances it is recommended that "clinicians use their best clinical judgement and knowledge of the best available research evidence to develop coherent treatment strategies" (p.275).

One such area of scant evidence relates to the presentation, assessment and intervention of posttraumatic stress disorder (PTSD) in older people (Bottche, Kuwert, & Knaevelsrud, 2012). The current prevalence of PTSD among older people living in the community (based on DSM-IV criteria (American Psychiatric Association, 2000) has been estimated between 0.7% and 4% (Maercker et al., 2008; Glaesmer, Kaiser, Braehler, Freyberger, and Kuwert, 2012; Van Ameringen, Mancini, Patterson, & Boyle, 2008; Chaudieu et al., 2011; Spitzer et al., 2008). According to the recently revised DSM-5 criteria (American Psychiatric Association, 2013), PTSD must follow exposure to a traumatic event and is characterised by symptoms of re-experiencing (flashbacks, spontaneous memories, recurrent dreams or other intense or prolonged psychological distress); avoidance (of distressing memories, thoughts, feelings or external reminders of the event); negative cognitions and mood (such as persistent and distorted sense of self blame and inability to remember the parts of the event); and arousal (including aggressive, reckless or self-destructive behaviour, sleep disturbances or hypervigilance).

There are presently no guidelines relating to the assessment and intervention of PTSD in older people. Guidelines based on evidence derived from adults of working age recommend trauma-focused cognitive behavioural therapy (TF-CBT) or Eye Movement Desensitization and Reprocessing (EMDR) (NICE, 2005). A summary of the few published studies reporting interventions for PTSD in older people will be presented. However, these must be considered in light of significant methodological limitations, including varying definitions of 'older adult' and use of different criteria for PTSD, variation in interventions, generally small sample sizes and few controlled trials. The majority of literature is based on single case studies or case series and although these offer useful preliminary evidence in support of particular approaches, there is likely to be a publication bias for successful cases, presenting a skewed picture of the effectiveness of these therapeutic modalities. Additionally, the 'trauma' population is heterogeneous and at the present time, little is known about the generalisability of research conducted on veterans to other groups of trauma victims, such as those who have experienced interpersonal violence.

A case series of three older people who attended group CBT following motor vehicle accidents reported significantly reduced PTSD symptoms and some reduction in depressive symptoms on completion of the group (Clapp & Beck, 2012). Snell and Padin Rivera (1997) devised a manualised group intervention including psycho-education, CBT skills training (anxiety, stress and anger management) in addition to life review, grief, loss work and forgiveness, but no outcomes have been reported.

A core component of TF-CBT is exposure, yet Shapiro (1995) and Hyer and Woods (1998) caution against the use of intensive exposure treatment with older people. They argue that increased levels of autonomic arousal could exacerbate potential health complications with medical co-morbidities such as severe cardiovascular or respiratory disease. However, two controlled studies with small numbers of participants have investigated exposure in older

adults and report reduction of post-traumatic stress symptomology (Gamito et al., 2010; Thorp, Stein, Jeste, Patterson, & Wetherell, 2012). Additionally, a number of case studies report promising results of exposure in older people (Russo, Hersen, & Van Hasselt, 2001; Markowitz, 2007; Duax, Waldron-Perrine, Rauch, & Adams, 2013). Although there are clearly significant limitations to the evidence base for exposure interventions, not least that most of the 'older adults' were under the age of 65, the preliminary findings suggest that exposure may be used effectively and safely with older people.

A number of single case studies have demonstrated effectiveness of EMDR in the reduction of PTSD symptoms in older people (Burgmer & Heuft, 2004; Hyer & Sohnle, 2001), however as yet no larger or controlled studies have been conducted.

In addition to the best available evidence, the evidence-based practice model requires clinicians to consider the context of patient characteristics, culture and preferences. These are further broken down into individual differences including; developmental stage, the patient's specific problems, strengths, personality, socio-cultural context and preferences (APA Presidential Task Force on Evidence-Based Practice, 2006). For clinicians working with older people a number of these considerations have the potential to present further challenges.

First, although there is insufficient evidence to demonstrate clear symptom profiles for age groups, and preliminary findings are contradictory, there appear to be differences in the presentation of PTSD in older people and adults of working age (Averill & Beck, 2000; Cook, Dinnen, & O'Donnell, 2011; Goenjian, Najarian, Pynoos, & Steinberg, 1994; Rodgers, Norman, Thorp, Lebeck, & Lang, 2005; Wolitzky Taylor, Castriotta, Lenze, Stanley, & Craske, 2010). Goenjian et al. (1994) found that older people tend to demonstrate higher hyper-arousal and lower re-experiencing symptoms than younger adults, a finding

corroborated by den Velde et al. (1993) though the latter offer no empirical evidence. On the other hand, Macleod, (1994) identified high levels of re-experiencing and arousal symptoms. In their review, Averill and Beck (2000) suggest a greater tendency for older people to report avoidance and emotional numbing, which can resemble depression.

Second, cohort effects may complicate the presentation, assessment and intervention of PTSD in older people (Bottche et al., 2012). Older people may not have a "normative language" (Cook et al., 2011) by which to understand and explain their experience. Additionally, beliefs and stigma regarding emotional distress and mental health problems may impact on reporting (Kimerling & Calhoun, 1994), and thus have implications for assessment.

Third, comorbid or complicating medical conditions are more likely in older people which can confound assessments (Cook et al., 2011), particularly in differentiating medical and psychological causes of anxiety symptoms (Kogan, Edelstein, & McKee, 2000). Furthermore, there is a tendency for older people to report more somatic symptoms (Blake, Cook, & Keane, 1992; Bonwick, 1998; Snell & Padin Rivera, 1997) and as most measures of PTSD are developed for younger adults with fewer somatic complaints, standardised measures may be less valid.

These preliminary findings would suggest that the evidence base for interventions of PTSD derived from the general adult population cannot be assumed to be equally relevant to the older adult population. Clinicians working in this area must therefore contend with making decisions based upon conflicting and limited evidence, in the face of complex client presentations.

Spring (2008, p.866) argues that decision making is the lynchpin of evidence-based practice "yet the literature on evidence based practice is mostly silent about how to accomplish

integrative, shared decision making." The APA is one of an increasing number of voices calling for greater investigation of process issues including decision making, to improve the effectiveness of psychological interventions (APA Presidential Task Force on Evidence-Based Practice, 2006; Hunsberger, 2007; Kazdin, 2008; Rhodes, 2012).

2. Aims

Given the lack of robust evidence base, the aim of the present study is to explore how clinical psychologists working with older people make decisions relating to the assessment and intervention of posttraumatic stress symptoms. It is hoped this information may be of value to clinicians working with this population and provide a basis for further research.

3. Method

3.1 Grounded Theory

Qualitative methodologies have a unique contribution to make to the investigation of process issues in psychotherapy, as they maintain the rich detail of complex processes (Kazdin, 2008; Rhodes, 2012). Grounded theory methodologies are based on the premise that reality is developed through social processes and aim to develop a substantive theory grounded in the perspectives of those with experience of the subject under investigation (Glaser & Strauss, 1967). Grounded theory has been utilised by a range of healthcare professions to provide explanatory frameworks for aspects of clinical decision making and judgement, including; clinical psychology (Dilks, Tasker, & Wren, 2008; Kam & Midgley, 2006), general practitioners (Kumar, Little, & Britten, 2003; Sigel, 2004), nursing (Elliott, 2010), physiotherapy and occupational therapy (Jette, Grover, & Keck, 2003).

3.2 Sampling and Recruitment

The study utilised purposive sampling, operationalised via the application of the following inclusion criteria: clinical psychologists who currently work with older adults or who have previously worked with older adults in their capacity as clinical psychologists; clinical psychologists who have worked (as the lead clinician) with a minimum of two older adult clients who have presented with posttraumatic symptomology; for practical purposes participants must have been based in Scotland at the time of participation.

An email containing participant information and consent forms was sent to heads of older people's psychology services across Scotland, each of whom forwarded the email to clinical psychologists working in their department. Recipients were requested to contact the researcher to express interest in participating. A total of nine clinical psychologists responded. It was not possible to arrange a meeting time with one, and so eight clinical psychologists participated.

3.3 Procedure

Semi-structured interviews were undertaken by the researcher, with the aim of gaining detailed descriptions of participants' experiences of undertaking assessment and intervention of posttraumatic stress symptomatology (PTSS) with older people. Thus, open questions and a flexible interview format were employed to encourage participants to determine the content of the interview. Follow up questions such as "can you tell me more about that?" were asked to seek additional information and clarification where it was perceived to be relevant. Participants were asked about PTSS and not PTSD per se because evidence suggests that the prevalence of PTSD in older people is relatively low, but a higher proportion experience partial PTSD (Creamer & Parslow, 2008; Glaesmer, Kaiser, Braehler, Freyberger, & Kuwert,

2012; van Zelst, 2006). Furthermore, it would have been impractical to ensure participants spoke only of clients who met diagnostic criteria.

Interviews were audio recorded, took place within participants' places of work, lasting on average 44.08 minutes and were transcribed verbatim by the researcher. Any participant or client identifying information was removed during transcription to maintain anonymity.

3.4 Quality and rigour

Yardley (2000) proposes the application of four principles to ensure quality and rigour in qualitative research: sensitivity to context, commitment and rigour, transparency and coherence and impact and importance.

3.5 Data Analysis

Data analysis was carried out in accordance with the methods described by Corbin and Strauss (2008). Analytic procedures were characterised by concurrent data collection and analysis, constant comparison, open coding, axial coding and theoretical sampling. Following transcription of the first three interviews, the researcher commenced open coding, which entailed the application of conceptual labels to segments of data, for example, 'developing understanding' and 'training'. The researcher's clinical supervisor independently open coded sections of the transcripts, differences were discussed and resolved. Memo writing was utilised as a means of abstracting the data, keeping track of the analysis and reflexivity, thus demonstrating transparency and coherence and sensitivity to context (Yardley, 2000).

Commitment and rigour (Yardley, 2000) are in part achieved through constant comparison of codes and memo-writing. Through this process, categories such as 'reflecting on sensitising experiences' and 'therapeutic relationship' were developed. Subsequent data were compared

to the emerging framework, facilitating the development of well-defined categories, with the codes explaining the context, properties and dimensions of the category. Gaps identified in the emerging categories were addressed through theoretical sampling (Birks & Mills, 2011). Relationships between the categories and codes were established by axial coding and the identification of a core category. Last, member checking (Lincoln & Guba, 1985) was utilised as a means of ensuring transparency and coherence (Yardley, 2000), in which participants were offered the opportunity to comment on the emerging theory Six participants provided responses, all of which suggested the model accounted for their decision making. A number of areas of the substantive theory were elaborated in light of their comments.

4. Results and Discussion

4.1 Balancing Complexity, Resources and Demand

The main theoretical category to emerge from participants' accounts was 'balancing complexity, resources and demand' which underpins decision making in this context, and forms the core category of the model. The relationships and interactions between the seven sub-categories which comprise the model are illustrated in Figure 2 and briefly summarised below. Of importance to note, is that the model represents a dynamic process in which the salience of the constituent parts changes throughout therapy. The findings are considered in the context of existing empirical literature, making links to extant theory.

Decision making takes place in the context of the NHS, but is influenced by and influences 'culture'. Continually evolving 'clinician competencies' are drawn on by participants as they seek to disentangle the multifarious components of "what the client brings". Balancing the

demands of therapy with clients' resources emerged as complex and ambiguous; made possible by 'reconciling understanding' and 'tailoring' assessment and intervention. The 'therapeutic relationship' both contributes to and is a product of maintaining an adequate balance.

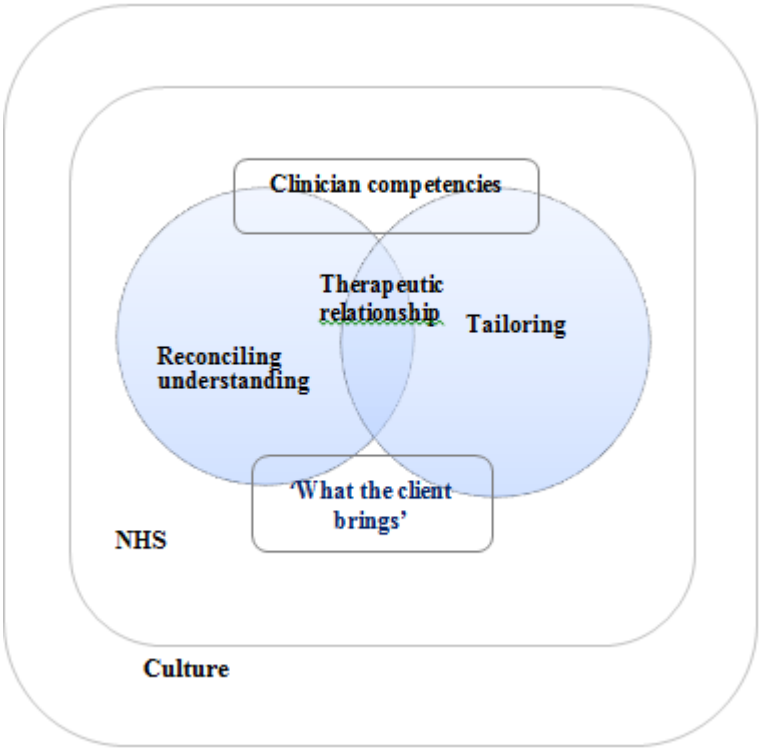

Figure 2 Balancing complexity, resources and demand

4.2 Culture

The contextual adult lifespan theory for adapting psychotherapy (CALTAP: (Knight & Lee, 2008) provides a framework for adapting psychotherapy for older people. Consistent with this theory, participants' conceptualisations of their clients encompass relevant 'cohort effects' and the wider cultural context. The influence of these factors on participants, professional colleagues and the NHS emerged strongly from the interviews.

4.2.1 Cohort effects.

A cohort is "a birth-year defined group that is socialised into certain abilities, beliefs, attitudes, and personality dimensions, which remains relatively stable with age and distinguishes the group from other cohorts" (Knight & Lee, 2004 p.61). A range of cohort effects were viewed as relevant to those currently eligible for older people's services, including: deference to medics; stigma surrounding mental health and language for emotional distress; all of which are well-established in the literature (Knight, 2004). Consideration was given to the influence of cohort effects on how clients view themselves, their trauma experience, symptoms, the beliefs they hold about coping and their expectation of services.

> *...people that you see who've grown up during the time of rationin', creates a certain mind-set I think (mmhhmm) that in my experience that you maybe don't see in today's society, or people's views about divorce or family dynamics or things like that, so it's about being aware that, those might impact on, impact on therapy in terms of, in term, in terms, in terms of the impact it's had on shapin' the patient's view of the world and of themselves.* (P3)

4.2.2 Present cultural influences.

Participants noted that greater media coverage of mental health issues and PTSD specifically, was linked with an increase in client understanding of PTSD, acceptability of experiencing and seeking help for it.

> *I mean I think it's changing within an older people's population as well, particularly with the young old as opposed to the old old, people are much more*

aware of psychological issues, people are more aware of psychological treatments, you know, it is more common place to see it on the TV. (P3)

Negative societal attitudes to ageing are well documented (Angus & Reeve, 2006). The proliferation of these by the media were viewed as influencing the beliefs held by older people, the family systems in which they operate and NHS culture.

4.3. NHS

4.3.1 Culture of service.

It was apparent that all participants had encountered some degree of ageist attitudes amongst health professionals. Evidence suggests that this is widespread in mental health settings influencing behaviour and the care provided (Blakemore, 2009; Herrick, 1997; Lookinland, 1995; McCabe, Davison, Mellor, & George, 2009).

I think, there seems to be some sort of blanket um, stigma or ageism. I think it's ageism actually where if, I I it's just like I was saying before really, that you know there seems to be mu- much more comfort in saying, oh it's late life anxiety, late life depression when actually it- you know, it's not, it's more than that, it's trauma, but that word just doesn't seem to be used. (P1)

Ageism amongst professionals provided the most strongly held of participants' explanations for why PTSD is often overlooked in favour of diagnoses more commonly associated with older people, such as depression, anxiety and dementia.

You know there's all this about the inevitability and understandability hypothesis that well they're old, you know, they've got lots of physical health problems, their wife's just died, obviously they're depressed. (P3)

Further explanations for what were perceived as frustratingly inaccurate diagnoses were consistent with those proposed in the literature. These include an interaction between cohort effects in the form of older people emphasising physical symptoms (Reynolds & Kupfer, 1999), reluctance to talk about symptoms, or a lack of language for doing so and health professional's focus on physical health (Cook & O'Donnell, 2005; Herrick, 1997). A number of participants conceded that differential diagnosis is often complex, particularly in the context of co-morbidity or physical ill health, which are known to confound assessment (Caine, Porsteinsson, Lyness, & First, 2000; Spitzer et al., 2008; Taylor, McQuoid, & Rama, 2004). An additional factor, not mentioned specifically by participants is that older people are less likely to seek help for mental health problems (Kimerling & Calhoun, 1994).

A concerning theme was clients being referred with a lifetime of failed help-seeking experiences, with symptoms never having been understood in the context of trauma.

> *I can think of a number of people that I've seen, who you know maybe had presented to psychiatric services over their life um, or even had spells as inpatients, but it was never really picked up why.* (P7)

The limited research in this area suggests that recognition of partial and full PTSD is poor (Busuttil, 2004) and indeed, trauma has been labelled as a "silent problem" because of the tendency for it not to be recognised (Thorp, Sones, & Cook, 2011). Untreated PTSD has been found to be persistent and episodic (Ronis et al., 1996), which has implications for physical health, wellbeing and subsequent health care utilisation (van Zelst, 2006).

Another theme within this category relates to the way in which local service systems and structure dictate participants' roles, degree of integration into multi-disciplinary teams and the nature of referrals received. Participants' experiences of multi-disciplinary working appeared to be largely dependent upon the attitudes of those within the team.

4.4. 'What the Client Brings'

"What the client brings" is an in-vivo code, encapsulating the array of factors which participants described taking account of throughout therapy. These consist of 'the trauma', 'life experiences', 'resources and complexities' and 'attitudes, beliefs and emotions' which are considered in the context of culture and cohort effects. CALTAP asserts that consideration should be given to negative and positive maturation and specific challenges such as inter-generational conflict, chronic illness, disability and caregiving (Knight & Lee, 2008). Participants' accounts give credence to this theory and suggest it is being implemented in clinical practice.

4.4.1 Resources and complexities.

Continuous consideration of the resources available to clients formed a core part of decision making throughout therapy. Participants described bearing in mind potential client resources and complexities, including; cognitive functioning, physical health, coping mechanisms, ability to trust, quality of relationships, social circumstances and emotional literacy. These concepts are fluid, moving along a continuum, their position on which guides the extent to which participants consider them a resource or a complexity.

> *...but you have to bear in mind I suppose cognitive impairment and possible physical things like hearing and eyesight and all that.* (P6)

These phenomena have the potential to create complexity by reducing coping skills, cognitive and physical resources available to clients. Moreover, they frequently overlap with PTSS, creating uncertainty and ambiguity about the aetiology of symptoms. One participant described "*trying to work out exactly what's what and what's the overlap"* (P7) highlighting the complexity of the work, which often requires the holding of numerous competing

hypotheses in mind. Whilst this complexity is well described within the literature, guidance on disentangling the issues has yet to follow (Thorp et al., 2011).

Unsurprisingly, as the literature confirms (Norcross, 2002), family or social support surfaced as a potential resource; however participants also noted the potential for family to create complexity, for example creating dependence in clients. One participant believed this was exacerbated by negative attitudes to ageing among older people and their systems, highlighting the links with wider culture and environment.

Another participant voiced strong views regarding the importance of identifying client strengths and using these explicitly as a resource.

> *And don't pathologise things that don't need to be pathologised basically, and emphasise their strengths, because they will have them if they've got to this point, they sure have got plenty of strengths.* (P8)

4.4.2 The trauma.

The trauma was considered from a number of perspectives with participants differentiating between 'complex and simple trauma'; the 'nature of the trauma' (e.g. abuse, traffic accident or war related traumas); and 'time since trauma'. In keeping with the literature, participants anticipated that clients who had experienced complex and interpersonal trauma would have greater difficulty establishing trust, which in turn has implications for client's support network and the therapeutic relationship (Courtois, 2004; Herman, 1997). The impact of childhood trauma upon attachment and personality development were also mentioned as considerations, in addition to the potential influence of these factors on clients' resources (Kessler et al., 2010; van Zelst, de Beurs, Beekman, Deeg, & van Dyck, 2003). van Zelst

(2003) demonstrated that even among older people, childhood adversity remains a predictor of full and partial PTSD.

> *Is it straight forward PTSD type thing or is it more like a kinda complex trauma (mmhhmm) maybe happened very early on in life? Um resulting in maybe attachment issues or disrupted relationships um, early maladaptive schemas.* (P2)

A strong theme in relation to the trauma was the amount of time elapsed since the event. A number of participants articulated the need to consider the wider impact of trauma on a person's life, for example in the decisions they have made as a result of their experience or symptoms, which may have created a domino effect.

> *…there's been 70 years of trauma that's never been treated and you know. And also because of that like the time, I suppose people have developed coping mechanisms (mmhmm) that then make treatment difficult.* (P1)

Facilitating clients to make links between past events and current distress was considered to be more difficult the longer the period since the trauma event.

> *I think a lot of the people I've seen that are older almost kinda have this, well it's gone, it's passed and they they struggle to understand why, given that this was seventy, sixty whatever years ago, 'why is this having an effect on me in the here and now?'* (P3)

Not only did clients' symptoms emerge as a focus of assessment, but also how they are experienced and understood, factors which have been shown to be associated with severity (Averill & Beck, 2000). Information relating to the quality of memories, such as flashbacks, intrusive memories; visual, auditory or olfactory memories were seen as pertinent for the tailoring of interventions.

…although she does have post-traumatic stress symptoms they're flashbacks to not a memory that you can visualise, but more feelings and somatic things. (P1)

4.4.3 Life experiences.

"Examining major stressors and life events in their historical context and locating these on a personal timeline" (Laidlaw & Pachana, 2009 p.605) is congruent with the developmental perspective to understanding clients' experiences voiced by participants.

I suppose really being aware of how old they are, what they've lived through and what they've experienced…I knew that stuff in Cyprus kind of happened in the fifties and sixties, no idea what that was. So went and I looked up so I had context for what he was telling me. (P6)

Taking a developmental view enabled participants to gain insight into how clients responded to challenges in the past, highlighting strengths or barriers (Laidlaw & Pachana, 2009). This included how clients and any significant others responded to the trauma; any previous help seeking experiences, either relating to the trauma or other mental health problems.

Current life events or circumstances such as retirement, housing or bereavements, have the potential to create further complexity, and are categorised as 'challenges' in the CALTAP (Knight & Lee, 2008). These represent potential drains on resources, or issues which may be more pertinent to clients than trauma symptomology. Knowledge of these issues enabled participants to consider clients' difficulties in their full context.

…they quite often will have had losses, people dying, retirement is a kind of a loss, n things like that can be part of the problem. (P2)

4.4.4 Beliefs, attitudes and emotions.

Cognitions about the self, others, the world and the future, and associated emotions such as guilt, shame, and anger are often the focus of interventions for PTSD (Stallworthy, 2009). Unsurprisingly, these were mentioned by all participants as fundamental to their conceptualisation of clients' difficulties.

Of equal importance was gaining insight into clients' beliefs about their symptoms, ageing, services and psychological therapy. These were considered in the context of cohort effects, present cultural influences and life experiences. For instance, a cohort belief of deferring to medically trained staff and perceived ageism amongst professionals, has potential to result in clients' expectations of psychology being inaccurate or unrealistic, influencing their motivation to engage.

> *...there's a cohort of people who are probably the oldest that we see who wouldn't ask for psychology but they've been sent and they don't really know why they're here.* (P6)

Two significant influences on client motivation and hope were mentioned by participants and are corroborated by the literature. First, older peoples' attitudes to ageing influence their beliefs about their ability to benefit from psychological therapy (Laidlaw, 2010). Second, when older people's past experiences of services have been negative, they often have difficulty trusting professionals and or lack motivation (Beck, 1995).

> *... can't really help me, I've had this problem for too long, um, I've tried loads of things, nothing works.* (P2)

4.5 Clinician Competencies

Clinician competencies are drawn on to direct assessment of "what the client brings" and subsequent interventions. Clear from the narratives was the evolving nature of clinician competencies, central to which is the process of 'reflecting on sensitising experiences', through which participant's 'knowledge, skills and style' and 'responsibility' are developed. Although two sub-categories, the two former are so closely linked that they are presented together for continuity.

4.5.1 'Reflecting on sensitising experiences' and 'knowledge skills and style'.

Diverse sensitising experiences include, but are not exclusive to, training; techniques or tools participants have employed; conversations with colleagues; supervision of others and personal experiences. In the context of their existing knowledge base, participants reflect upon and hypothesise about mechanisms of perceived success or disappointment, noting patterns in presentation and responses to different approaches. Participants' experiences and reflections influence the cues they pick up on, the approaches and tools they employ with whom and their confidence in doing so.

> *I don't actually like to do um what they talk about in Level 2 EMDR too much which is um, that kind of installing positive beliefs or that kind of thing using eye movements. I don't really go a bundle on that, not somethin' that I've found all that effective, um so I prefer to do the EMDR for the trauma and then use the CBT for all the negative beliefs and so on.* (P2)

According to Norcross (2002), 36% of clinical psychologists claim to be eclectic or integrative. The majority of participants either expressed this position *"I guess probably a lot of psychologists say, would hope to be fairly eclectic" (P7),* or implied it. The process of

reflection and hypothesising as "local clinical scientists" (Stricker & Trierweiler, 1995) is what distinguishes integrative therapists from eclectic therapists, who repeat what has appeared successful without consideration for the mechanism of change (Jones-Smith, 2012).

> *…and I don't know to this day why he defaulted but I don't know whether he just didn't feel comfortable about talking with a young lassie kind of thing, d'you know about stuff that um, you know was really hard to talk about to anyone.* (P7)

'Reflecting on sensitising experiences' emerged as the means by which participants developed and assimilated knowledge; including the specific demands placed on a client by an approach or task and the potential gains offered. The trust necessary for a client to discuss their difficulties with a stranger, the cognitive flexibility required for cognitive restructuring and the emotional load of re-processing trauma were some of the demands identified.

> *… you can take it slower with CBT, you can't control the pace of EMDR to the same degree.* (P6)

The more experienced a participant was in utilising an approach, the greater their confidence in their ability to judge potential demands and gains for individual clients.

> *…and I think I've just seen the power of how much it can really change um, people's sort of emotional response and um, reaction, how beneficial it can be.* (P7)

Holding in mind the relevant model(s) enabled participants to hone in on pertinent aspects of clients' narratives in assessment, develop hypotheses, make predictions and be creative with interventions.

> *I think you can be quite creative with PTSD, I think as long as you remember what it is you're trying to achieve and what the model is and what it would*

predict, then I think from that, it's fine to be quite creative with how you go about it for an individual person, um depending on what would be meaningful and acceptable to them. (P8)

These accounts resound with much of the extant literature regarding expertise, which highlights the ability of experts to recognise relevant patterns and organise information in ways which reflect a deep understanding of the subject matter (Bransford, 2000, p.31; Elstein, 1988). This organisation facilitates the automatic retrieval of information and the ability to adapt information to new situations. Monitoring knowledge and identifying when this is inadequate are also hallmarks of expertise

However, Garb (1998) contends that expertise in psychotherapy is often limited by the feedback clinicians obtain, arguing it is generally non-existent, inadequate, biased, and or inaccurate and misleading. This has which has the potential to provide "the illusion of learning from experience" (Dawes, 1994, p.122). The use of measures to monitor progress is posited as one strategy to reduce this risk (Garb, 1998). Others include the use of semi-structured interviews, taking a scientist practitioner stance, with a strong role for supervision also recommended (Bell & Mellor, 2009; Garb, 1998).

Few participants described regularly using outcome measures and only two participants briefly mentioned supervision. It would seem that this inherently idiosyncratic process of professional development has the potential to leave clinicians vulnerable to overgeneralisations, confirmatory biases, misinterpretations and other errors in judgement (Garb, 1998; Goldfried, 1999; Grove, Zald, Lebow, Snitz, & Nelson, 2000; Grove & Meehl, 1996).

4.5.2 Responsibility.

A number of participants articulated the view that when working with people who have experienced trauma, there is potential to exacerbate symptoms and do harm. With this knowledge, participants expressed an increased sense of responsibility for clients which appeared to be further exacerbated when clients were particularly frail, or held strong beliefs regarding deference to professionals.

> *…it can border on slightly abusive sometimes to go in with therapy that you don't think the person's going to cope with depending on their situation. Um, but what else with older people… I think it's giving them choices. I think one of the other things is sometimes with older people that they can, they can be more compliant than younger people would be just because of the cohort beliefs they have.* (P8)

Mindful of their responsibility, participants with less experience of working with PTSS were conscious of working outside of their therapeutic comfort zone. A minority believed a lack of confidence in their ability to effectively monitor client progress had resulted in having avoided exposure work.

> *I didn't feel I was, yeah as expert on picking up on things and and you know, getting him to face some of those things. And I just, and that's partly because I didn't feel confident enough I think.* (P5)

These participants described feeling torn between obligations to offer evidence based interventions and ensuring client welfare. Lack of training and concern about doing harm have been identified as explanations for why exposure therapy for PTSD in adults of working age is widely avoided by clinicians, despite evidence for its efficacy (Becker, 2004). As discussed in the introduction, literature pertaining to older people has cautioned against the

use of exposure (Hyer & Woods, 1998; Shapiro, 1995), but only recently has any evidence been presented. In contrast to that caution, Thorp et al. (2012) demonstrated effectiveness of exposure with no adverse consequences for health.

To some extent, sensitivity to ageism arose in all participants' accounts, which appeared to stem from a perception of implicit ageism amongst professionals within the NHS. Subsequently, a responsibility expressed by the majority of participants is their role in influencing the attitudes of other professionals through 'reconciling understanding' which is further elaborated below. Participants who reported greater involvement in multi-disciplinary working unsurprisingly had greater experience of this.

> *I take the attitude that older adults are adults you know, and aren't a distinct different species that I think is sometimes the connotation.* (P1)

4.6. Reconciling Understanding

Four sub-categories comprise 'reconciling understanding'. First, participants use 'establishing realistic expectations' to engender in clients a sense of trust and control. Second, a continual process of formulation was evident in the accounts, with participants reconciling their understanding of "what the client brings" with their existing knowledge base. Third, participants create a 'shared formulation' with clients, enabling shared goals and informed choice where appropriate. Finally, 'reconciling understanding with other health professionals' includes consulting with others, managing professional conflict and influencing the culture of services.

4.6.1 Establishing realistic expectations.

Participants stressed the importance of 'establishing realistic expectations' with clients regarding potential outcomes, the nature of the therapy process and clients' roles within that.

I've certainly had the experience of older people coming in and particularly, older women, sitting with their hand bag on their knee and after twenty minutes, 'oh I've taken up enough of your time doctor', ok that's, and then I'm realising I haven't explained this to them. I haven't you know told them what to expect here, you know that's my fault. (P8)

Client expectations of treatment and outcome have been shown to have a significant impact on the therapeutic alliance and outcome (Greenberg et al., 2006; Constantino, 2005; Greenberg, Constantino, & Bruce, 2007). Joyce, Ogrodniczuk, Piper and McCallum (2003) found that where goals were seen as within reach, clients were more likely to collaborate in therapy, resulting in better outcomes. Addressing the expectations of older people early in therapy, which are often influenced by cohort effects is strongly emphasised in the literature (Cook & O'Donnell, 2005; Knight, 2004). In the early phases of therapy, this sub-category is characterised by psycho-education and socialising clients to psychology.

...a lot more repetition and a lot more, ground work at the beginning, much longer assessment phase, um, much more psycho- education and more therapeutic relationship building. (P1)

At times however, clients present with clear and realistic goals and participants viewed their role in such instances as facilitators.

...it would have been so wrong to march in there and say 'no, I'm the expert on trauma, I know what to do'. No, he was the expert on his trauma, he knew what had worked for him over the years and what he needed from me. (P8)

Participants aimed for clients to understand the rationale for each therapeutic task, in addition to the demands and potential gains it offers. This was of particular relevance where the

potential for an exacerbation of symptoms was greater. Establishing realistic expectations was the basis from which participants sought to normalise client experiences of therapy, manage avoidance, develop hope and motivation, tackle stigma and create a foundation from which informed choices can be made.

> *…their initial um reaction to that was oh you know 'that's useless, I've tried that before, it doesn't work' you know…but actually they were quite willing to try things again. I think when it it's kind of part of an explanation of how anxiety works and things like that and hence why, why, why we would want to do, why we would want to try, why we would want to try something like relaxation and breathing exercises things like that.* (P4)

'Reconciling understanding' offered one means by which to build trust with clients and engender a sense of control. This is paramount when working with people who have experienced a loss of control as a result of a trauma (Herman, 1997; Stallworthy, 2009).

> *I think there are such issues of control with PTSD um, that it's, I think it's really vital to make sure that the person um, feels understood, but equally knows that they have the control and that you're not going to launch into um asking them about things that they really, that they've spent perhaps years and years trying to keep a lid on.* (P8)

Ford, Courtois, Steele, Hart and Nijenhuis (2005) suggest that in the treatment of complex trauma "education enables the client to begin to experience the therapist as consistently present and helpful, rather than as withholding, controlling, rejecting, mysterious, or dangerous" (p.438). Similar to the present model, this is undertaken in the first stage of therapy, and was termed stabilisation by Ford et al. (2005).

This category represents one of numerous aspects of this model relating to 'non-specific' components of therapy which as described, serves a number of diverse functions.

4.6.2 Clinician formulation.

Formulation is core to clinical psychology (Johnstone & Dallos, 2006) and so as one might expect, the 'clinician formulation' emerged as a framework for understanding the relationships between complexity, resources and demands. Participants described a dynamic process of reconciling their understanding of clients' difficulties with their knowledge base. This was characterised by continual development of a series of competing hypotheses to be rejected, strengthened or confirmed. Particularly where cognitive and physical symptoms overlap with PTSS, participants had to contend with significant ambiguity and uncertainty.

> *...got a bit of cognitive impairment as well so it's actually quite tricky trying to sort of work out ok, I'm fairly sure from his history and from the sort of um, longevity of some of his difficulties that the blankness and detachment relates to sort of numbing (mmhhmm). But part of me also wonders is there any element of that that's to do with sort of some of the cognitive changes or lack of alertness or, 'cos there's a sort of query of a lewy body dementia so. Yeah I suppose that's a challenge in that particular case, just trying to work out exactly what's what and what's the overlap so yeah....* (P7)

The extent to which participants shared their formulation with clients depended upon their style, the ability of clients to understand it and how helpful it would be to them.

> *...the sort of child rearing practices, um, if you went in there thinking that's, I mean it is awful, but if you went in that there and expressed that too much to the*

patient, actually how helpful would that be to them, how therapeutic would it be to them? (P3)

Inevitably, sections of the formulation are not shared, as they are complex and dynamic mental representations.

4.6.3 Shared formulation.

Goal consensus and collaboration have been found to have a significant impact on the outcome of psychotherapy (Tryon & Winograd, 2011). The 'shared formulation' in conjunction with having established realistic expectations emerged as the bedrock of collaboration and developing realistic goals.

I think you have to respect the fact that, if it's going to take a long time from them to get from a to b, they have to understand that fully, what that actually means, and if they are quite physically frail or um, they have a lot of things to contend with in their lives, perhaps bereavements etcetera, you've gotta be realistic about the person's um, resources I think, it's only fair to them to be realistic about those things. And I think you know, all the more reason to formulate properly and talk to the person about poss, possibilities and what you know routes they would want to take. (P8)

Moreover, for all participants, the 'shared formulation' is a means of demonstrating empathy, building the 'therapeutic relationship' and making clear links between past events and current distress.

And I think for me that's why formulation is really important and can be a really powerful technique for change, because I think it it means that you, you've got a,

it's a collaborative approach, but you're also workin' in a way that shows the patient you're understanding them, and that I think can be really helpful. (P3)

4.6.4 Reconciling understanding with other health professionals.

Seeking out professional colleagues for their opinions to reconcile understanding, was mentioned by a minority of participants, who valued the contribution to their professional development; whereas differences in professional opinion were common for other participants.

…what I've found is that people actually want to know what's wrong and what their diagnosis is. Which is a bit difficult to- it's a bit difficult when different professionals have a different idea of what to do. (P1)

Sharing their formulation was the primary means of seeking to reconcile understanding with professionals. The aims of which appeared to be twofold; first, to improve care for an individual client; and second, to influence the attitudes and practice of professionals within the service, improving the equity and quality of care for older people.

*... it's getting people to refer people who have those symptoms, or even for them to just recognise that that's what it might be, and to look out for it. Because plenty of old people are burgled and mugged and all the rest of it, and I wonder how many GPs know about those things, but don't actually keep an eye out to say, 'how are you coping now? (*P6)

4.7. Tailoring

The narratives suggested that clinician competencies are drawn upon to tailor the assessment and intervention to the client, with the aim of 'balancing complexity, resources and demand'. 'Being responsive' to the client's experience of tasks enables participants to match their

approach to individuals and build resources accordingly. At times matching entails integrating approaches, and at others using one therapeutic approach flexibly.

Although a number of reasons for taking an integrative approach are postulated, they lack empirical evidence gathered 'in-vivo' (Schottenbauer, 2007). Clinicians have been shown to believe that integrative approaches better meet the needs of individuals, that goals can be met in a shorter period of time and that they are more adaptable to a range of clients (Norcross et al., 1996). Taking an integrative approach is thought to often be a response to challenges which arise, such as stalling (Goldfried & Castonguay, 1992; Goldfried, 1999; Norcross et al., 1996). Beutler and Martin (2000) have identified four categories of variables relevant to selecting therapeutic techniques each of which are accounted for in the current model: patient predisposing variables, including expectations, treatment context, relationship qualities and interventions, and selection of the strategies and techniques that best fit the patient.

4.7.1 Being responsive.

'Tailoring' commences the instant clients arrive; initially through monitoring their response to the situation, trying to judge what resources are available to them, and 'being responsive' to that.

> *...when we started to explore issues in this person's um, childhood, that really raised a lot of difficulty, a lot of anxiety, so we had to sort of look at that for a wee bit before we kinda moved on to other things.* (P4)

Each subsequent decision, be it the use of a questionnaire, a therapeutic technique, or whole manualised approach is considered in terms of the demand it is likely to place on an individual client, and their perceived resources to cope with that.

So that that's actually a really helpful thing to do if people have got the verbal ability to make use of the questionnaire, because it is very, very lengthy. (P2)

As resources such as coping are fluid in nature, at times predictions about the course of resources have to be made to inform decision making.

...you could go through all doing that work and then um, he, as his dementia progressed it would all be kind of really undone, (mmhhmm) and he wouldn't have the cognitive resources to cope with it, um or to to be able to put in, the therapy into practice. (P5)

One participant, mindful of the potential to do harm, noted apprehension following intensive sessions when it was not possible to monitor a client's delayed response to an intervention.

there's always a bit of therapist anxiety at the end of a session like that, even if the person's kind of you know, calmed down at the end sort of just wondering how they're gonna be between then and the next session, because you don't, don't know how that is. (P7)

Evidence suggests that therapist's ability to accurately monitor outcomes and progress of their own clients is poor (Hannan et al., 2005; Hatfield, McCullough, Frantz, & Krieger, 2010). Only two participants referred to using measures routinely as part of assessment and monitoring progress. Shimokawa, Lambert and Smart's (2010) meta-analytic findings suggest a significant reduction in cases terminating when regular monitoring is implemented, and that monitoring has particular relevance when not adhering to manualised treatment protocols.

4.7.2 Matching.

Integration of "what the client brings" and client goals in the 'clinician formulation', provide the basis for decisions regarding which psychological intervention to choose. However, given the complexities participants described facing, even at this stage, often considerable uncertainty remained in formulations, which was managed by establishing realistic expectations. In selecting an approach, particular emphasis was placed upon factors associated with 'the trauma', (complex or simple, time since trauma, the nature of the symptoms) and the beliefs the client holds regarding the event. These factors tended to sway participants towards EMDR, schema therapy or trauma focused CBT, depending upon their individual 'clinician competencies'.

> *And I guess the other sort of side of the work would be more general sort of cognitive work I guess around um, you know how it's made them feel, how they responded you know, the situations they're avoiding or how they're now perceiving particular things. Or in a case of something like abuse work it would be more um, sort of looking at some of the needs that weren't met and you know…* (P7)

One of the major criticisms of the decision making literature is its failure to take account of the relational nature of decision making in psychotherapy (Elliott, 2010; Street, 2007). It emerged that a minority of participants would not routinely offer choice, using a CBT based approach. The variation in practice appeared to stem first, from the training a participant had had; second, a lack of experience and confidence in utilising some approaches was acknowledged. These participants suggested this would make them less likely to offer some approaches as an option, particularly in complex cases.

Third, the presentation of only realistic options based upon their formulation, which in addition to the factors above, meant in some instances only one option was appropriate.

> *Sometimes I decide the person's not suitable for EMDR or they're not strong enough to cope with it because it is quite, the exposure is quite intense, whereas with CBT it's easier to reign it in if you feel it's gettin too much, and sort of pace it easier.* (P6)

Fourth, it was acknowledged that this level of collaboration poses a challenge with some clients, particularly where the cohort belief regarding deference to professionals is strongly held or when clients have cognitive impairment. In such instances participants found themselves being directive, guided by their 'clinical formulation'.

> *Um, I suppose if you're doing trauma focused CBT or CBT in general, getting somebody to collaborate if they're not used to that, I think it's a lot, lot harder with older people. Um, and you become probably a bit more didactic than you want to, but sometimes you can't avoid it.* (P6)

Discrepancies between the demand of a task and client resources were addressed through participants either 'building resources', adapting the task, selecting an alternative approach or adjusting goals for therapy. At times, it was determined, often collaboratively that a client had insufficient resources to meet the demands of therapeutic work and psychological therapy was not pursued.

A number of participants revealed the belief that on occasion they had not adequately balanced the complexity of the problem, the demands and available resources. Having previously established expectations appeared to have a role in mediating the impact of this.

*'You're not managing this, it's ok, if that's the case'. And then looking ok, 'are there some other things you could be doing here that would be less difficult that might still be helpful', or is it much more about backing off and perhaps looking at more behavioural stuff rather than dealing with the real underlying issues. (*P8)

Participants hypothesised that not having established realistic expectations of a task influenced non-attendance of subsequent sessions. Other consequences included exacerbation of symptoms with which the client struggled to cope, deterioration in trust and having to repeat steps in therapy.

And I suppose I can think of other cases in the past, um, where I, if someone's defaulted really quite early on when you've started talking about um, you know, or they've maybe sort of told you some of their experiences and you know, they maybe just haven't felt comfortable going there or... (P7)

The need to continually balance resources and demand is not dissimilar from the 'window of tolerance' model proposed by (Siegel, 1999) which refers specifically to the autonomic nervous system's response to trauma. Clinicians use the window of tolerance model to judge the optimal level of arousal in which emotion can be experienced and therefore processed. Not only is this relevant for those clinicians undertaking exposure with older people, but in addition they consider the various other factors which must be balanced.

4.7.3 Building resources.

Building resources is a response to situations in which clients are judged to need more resources to undertake a task. Examples include developing client coping mechanisms, supports and activities.

I think I would try and build up their lives a bit more before, I'm just thinking well that, would that actually stop me from doing the PTSD work? But um, I suppose I would want them to have like kinda support, so that if they were finding the exposure work difficult and they were becoming more dissociated out with sessions and things like that, they would have support. (P5)

Some techniques were used to develop the relationship, others, including exposure were described as being contingent upon a sound therapeutic relationship already having been established. A view consistent with expert opinion (Cloitre, Koenen, Cohen, & Han, 2002).

Do some visual imagery and uh, this would be after we've got a good therapeutic relationship going, I certainly wouldn't do this in the first few sessions. (P2)

Participants had different strategies for increasing motivation, some of which are established in the literature (Constantino, 2005).

I think one of the things that can help is if you get an early success, an early win if you like. (P2)

A number of participants described having determined from referral information, through assessment, or if progress stalled, that the client lacked the cognitive ability to make sufficient progress with individual therapy.

…we went down the exposure route and then, it was clear that the dementia was getting too, he was forgetting things and uh… (P5)

In these instances, either the client was discharged, or their lack of resources was compensated for by the system around them. In such cases the system, either professionals, families or both were the ones with whom an understanding was reconciled and an intervention developed.

> *I've kind of just tried to work through staff really and then kinda be mindful of that when they're working with somebody. Mainly from the point of view of, of explaining to the staff who are working with them that that might be, I'm hypothesising that that might be what's going on.* (P4)

The involvement of family in therapy is a technique strongly advocated by Koder (2007) even when clients are cognitively intact.

4.8. Therapeutic Relationship

Fundamentally, all aspects of therapy have some relational impact, such that the therapeutic relationship cannot be separated from method (Safran & Muran, 2000). All participants viewed the therapeutic relationship as paramount to the process of balancing complexity, resources and demand, but also as a product of having adequately done so. Largely, the development of the alliance was achieved through reconciling understanding and tailoring assessment.

> *I think the therapeutic relationship is our one and only tool no matter what therapy you're doing, whether it's CBT or EMDR or whatever, if you don't have a good relationship with somebody, you're not gonna be very effective, and so taking time to get to know somebody, being able to show that you're very interested in them, um, having empathy and rapport and that kind of thing.* (P2)

4.9. Summary

The substantive theory 'balancing complexity, resources and demand' is grounded in interviews with eight clinical psychologists. The model highlights the complexity and uncertainty which characterises decision making by clinicians working with older people who present with PTSS. The seven sub-categories which comprise the model are broadly

consistent with existing literature (Blakemore, 2009; Knight & Lee, 2008; Norcross, 2002; Safran & Muran, 2000).

Participants' descriptions of cultural ageism and health professional's lack of awareness regarding trauma are corroborated by the extant literature (Blakemore, 2009; Busuttil, 2004). This model proposes that clinical psychologists seek to address cultural ageism, at least in part, through their clinical work. The accounts offer support to the principles proposed by the CALTAP (Knight & Lee, 2008), and suggest they are employed by participants in this context. The current model elaborates on the detail of how this process is implemented.

Flexibility appeared to be central to balancing complexity, resources and demand, either using a single therapeutic approach or by integrating approaches. Indeed, Castonguay (1996) reports that cognitive therapy is more effective when delivered flexibly. In keeping with findings by Goldfried and Castonguay (1992) and Norcross et al. (1996), the primary purpose of integrating approaches was to meet specific needs of an individual, or in response to a challenge such as stalling.

Although a minority of participants made reference to the use of outcome measures and supervision, it was not apparent that these are made use of as regularly as evidence suggests they should be (Shimokawa et al., 2010). In combination with the intrinsically idiosyncratic process of professional development, it could be argued that participants are vulnerable to overgeneralisations, confirmatory biases, misinterpretations and other errors in judgement. However, evidence suggests that the vast range of variables which clinicians are faced with exceed the human information processing capacity (Snyder, 2000, p.58), and therefore the use of heuristics (Tversky & Kahneman, 1974) to save time and cognitive effort seems inevitable.

The relational nature of decision making and importance of non-specific factors emerged strongly in the form of 'reconciling understanding', 'tailoring' and the 'therapeutic relationship'. Consistent with the view expressed by Safran and Muran (2000), participants nurtured the therapeutic relationship via the use of therapeutic tools in the form of reconciling understanding and tailoring. These processes provide participants with the foundation for collaboration and the development of realistic goals, which have been demonstrated to influence treatment outcome (Constantino, 2005; Greenberg et al., 2007).

5. Conclusions

The current study highlights the many factors involved in clinical decision making relating to the psychological assessment and intervention of PTSS and the impact these factors have upon clinicians; however, the findings should be considered in light of its strengths and limitations. First, it is not possible to extrapolate actual decision making behaviour from interviews. Inevitably, recall bias is likely to play a part in participants' recollections and it is possible that accounts might have been inadvertently crafted to reflect the extant literature. While this cannot be ruled out, aspects of the narratives suggest this is unlikely. For instance, supervision, a professional requirement did not feature in accounts to the extent that one might have expected. Providing unwitting evidence that interviewees were not simply giving what may be considered a desirable account.

Second, constraints imposed by limited time and resources mean the analysis is based on a relatively small sample. The definition of saturation offered by Corbin and Strauss (2008, p. 263) does seem to have been met; "the point in analysis when all categories are well developed in terms of properties, dimensions and variations. Further data gathering and analysis add little new to the conceptualization, though variations can always be discovered".

However, further data collection and analysis would have provided the opportunity for a more refined process of reliability checking.

Third, participants were self-selecting, and therefore it could be argued they had greater interest in the area or considered themselves to be experts. However, one of the strengths of this study was the inclusion of participants who felt less confident, with relatively little experience working with this population, in addition to those for whom it is an area of interest; therefore greater variation in practice can be accounted for by the model. A further strength lies in the achievement of the project aim, to provide rich detail of a specific decision making process. As Yardley (2000) stated, the ultimate test of quality is the usefulness of findings to those for whom they are intended. The use of member checking suggests that the model does account for variation in the decision making of six of the eight participants included in this study.

The model has a number clinical and service implications. While efficiency is increasingly an area targeted by services, the present model highlights the importance of clinicians being afforded adequate time in which to be able to balance the complexity, resources and demands which characterise work with this client group. Clinical psychology, with its expertise in formulation would seem to be well placed to undertake assessment and intervention of PTSS in older people which requires the consideration of a great range of potential complexities and the holding of numerous competing hypotheses. A further implication however, is the potential for contribution of other professional's expertise to reconcile understandings of clients' difficulties in joint formulations. On the basis of this study and the extant literature, there is still work to be done to address negative attitudes to ageing amongst health professionals and improve awareness of the need to assess older people for PTSD. Integrated multi-disciplinary teams with clinical psychology offering supervision would not only facilitate multi-disciplinary formulations and interventions, but also offer an opportunity to

influence wider attitudes to ageing and ultimately improve quality of care for older people experiencing PTSS.

The range of confidence apparent in this small sample would suggest that even among clinical psychologists, greater emphasis on this work in training might result in more regular adherence to evidence based guidelines regarding exposure. A number of models have been developed to support the use of integrative therapies and research relating to their effectiveness (Beutler, Moleiro, & Talebi, 2002; Brooks-Harris, 2008). Clinical psychologists, particularly those working in areas with a scant evidence base, may be well served by a working understanding of these. The use of outcome measures, whilst contentious, may improve outcomes by providing more objective feedback.

The present study offers a substantive theory of decision making by clinical psychologists working with older people presenting with PTSS. However, the extent to which the emergent model overlaps with the extant literature pertaining to clinical decision making with PTSS in adults of working age hints at the possibility that the model may have universal application. Clearly, further research to develop a formal theory to account for decision making in other client groups presenting with PTSS would be necessary.

Further research of the actual decision making process relating to PTSS which is less reliant on clinician recall is warranted. Future research could consider analysis of recorded therapeutic sessions using the information processing theory in order to understand "what knowledge structures, cognitive operations, and rule structures are necessary and sufficient to reproduce the observed clinical reasoning" (Elestein, 1998, p.19). Interviews with clinicians following the therapeutic sessions using reflective prompts would enable investigation of their thoughts and emotions during therapy and clinician's intended goals. Parallel interviews with clients would provide information regarding their experience of decision

making. Decision making guidelines based on such findings would have ecological validity which existing guidelines relating to decision making largely lack.

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CHAPTER 3

METHODOLOGY

Methodology

This chapter will describe the methodological processes involved in this study. It is broken down under the following four subheadings: 1) Design; 2) Participants and ethical considerations; 3) Procedure; and 4) Data analysis.

Design

The traditional research paradigm within psychology assumes that "reality consists of a world of objectively defined facts" (Henwood & Pidgeon, 1992, p.98). As such, the dominant form of inquiry has been to test hypotheses to determine a causal relationship. Whilst this form of research clearly has its place within the discipline, there is increasing pressure for clinical psychology to address the processes within therapy in such a way that cannot be distilled into hypotheses. Qualitative methods are proposed as one means by which to achieve this goal (Rhodes, 2012).

Qualitative methods facilitate the investigation of processes and mechanisms, which link variables through the explanations offered by those with experience of them. This inductive form of enquiry permits the exploration of social processes in their full, rich and intricate detail. Moreover, qualitative methods offer a means by which to clarify how the macro is translated in to the micro, to influence the behaviour of individuals (Barbour, 2007).

The reasons for selecting a qualitative methodology to meet the aims of this project were twofold. Firstly, the paucity of evidence relating to post-traumatic stress symptoms in older people would have limited the options for the development of meaningful hypotheses to test. Of greater relevance however, was the author's desire to develop an authentic understanding of decision making by clinical psychologists in this context by embracing its full complexity.

There are numerous criticisms of qualitative methodologies, among them the subjective nature of the enquiry and questionable generalisability of the results (Mays & Pope, 1995). Henwood and Pidgeon (1992) however, suggest that qualitative research offers "a view of the scientific process as generating working hypotheses rather than immutable empirical facts" (p.99). This quote illustrates the fundamental epistemological and ontological differences between qualitative and quantitative methodologies, and how they can make complementary theoretical contributions to the evidence base.

Different qualitative methodologies offer researchers the option to utilise the same data to achieve varied research goals. As such, a number of methodologies were considered to address the stated aims of the project. Phenomenological approaches seek to develop understanding of the meaning, structure and essence of the lived experience of the phenomena. The focus is on providing a rich description of "*what* is experienced and *how* it is experienced" (Wertz, 2011, p.125)

The premise of discourse analysis is that language forms the tool through which reality is mediated and constructed. Therefore language is the means by which people develop and maintain ideas, relationships and understand social processes. Through the careful analysis of language, it is possible to examine how identities are constructed, the nature of social norms, and interactions at both micro and macro levels (Starks & Trinidad, 2007).

Grounded theory methodologies contend that reality is created through social processes. The methods provide tools to facilitate the development of an explanatory theory of the social process under investigation (Glaser & Strauss, 1967). Thus grounded theory methodology was considered to offer the best fit with the stated aims of the project. The result will be the development of a substantive theory of clinical decision making in relation to assessment and intervention of post-traumatic stress symptomology in older people.

Historical Context of Grounded Theory

Glaser and Strauss, sociologists, first described grounded theory in their seminal text, *Discovery of Grounded Theory* (1967).Their text provided researchers with the systematic procedures by which to develop a theoretical account of a topic under investigation, grounded within the research data. Glaser and Strauss took a positivist approach to grounded theory and asserted that the researcher assumes a position of neutrality within the process. Through abstracting the data, latent patterns emerge, and that from this materialises an objective reality, a position which Glaser (2002) continues to defend.

However, Strauss moved in a post-positivist direction with Juliet Corbin, contending that the researcher is inherently involved in interpreting the data to form a theory (Strauss & Corbin, 1990). Moreover, Strauss and Corbin provided procedural guidance on methods to enable researchers to analyse data and develop theories. Glaser (1992) and indeed Charmaz (2011), consider these procedures to be prescriptive and a means of forcing the data.

The third generation of grounded theorists have taken a more constructivist view on the nature of reality and therefore methods of enquiry. Charmaz (2006) believes that data are constructed through a shared interaction between the researcher and participant, who are each influenced by their own beliefs, culture and context. Furthermore, in the process of analysis the researcher actively constructs a version of reality that is bound in context and time, and therefore cannot be replicated.

Interestingly, in the third edition of their book, *Basics of Qualitative Research* (Corbin & Strauss, 2008), published after the death of Strauss in 1996, Corbin sets out her own position independent from the view expressed by the duo previously. Corbin makes explicit the extent to which her position has been influenced by the writings of contemporary feminists, constructionists and postmodernists:

> *"I agree with the constructivist viewpoint that concepts and theories are constructed by researchers out of stories that are constructed by research participants who are trying to explain and make sense out of their experiences and/or lives, both to the researcher and themselves. Out of these multiple constructions, analysts construct something they call knowledge… I believe analytic work necessitates some degree of conceptual language to talk about "findings". Without conceptual knowledge there is no basis for discussion, conflict, negotiation, or the development of a knowledge based practice… Knowledge may not mirror the world, but it does help us to understand it".* (Corbin & Strauss, 2008, p.10)

In addition to a clear movement towards a constructivist approach in terms of methodology, in the third edition, the emphasis changes from prescriptive procedures, so strongly criticised by Glaser (1992) and Charmaz (2011), to flexible analytic tools. The strategies are presented as a guide for researchers to use as they interrogate the data, but do not require strict and rigid adherence to them.

Epistemological Considerations

The researcher's own ontological and epistemological stance is characterised by critical realism, proposed by (Bhaskar, 2010). Bashkar contends that reality exists independent of humankind, however that phenomena can never be fully experienced or investigated. Thus all research is limited by context and the process itself. He proposed that whilst knowledge cannot be an exact replication of reality, "knowledge may be positively applied to assist technical and medical progress" (Cruickshank, 2012, p.71). The researcher believes that this stance is most closely aligned to that described by Corbin (Corbin & Strauss, 2008), and what is more, in considering the methods described by Charmaz (2006) and Corbin & Strauss (2008) the researcher felt more comfortable with the analytical methods described by the

latter. These were seen as offering greater guidance in terms of method, however can be utilised flexibly so as not to stifle creativity, an integral component of developing grounded theory.

Rigour

In striving for quality and rigour, four principles for assessing qualitative research developed by Yardley (2000) were adopted: sensitivity to context, commitment and rigour, transparency and coherence and impact and importance.

Sensitivity to context requires the researcher to give consideration to the social-cultural context in which the research takes place. Attention should be paid to the relationship between participants and researcher and how this may influence the resulting data. Sensitivity to the theoretical context in which the research sits should be demonstrated. Similarly, the researcher should be clear about how their own perspective may impact upon the data. This entails scrutinising the data for coherence or variance to previous assumptions, ensuring any differences are explicated in full and not taken for granted.

Commitment refers to the to the researcher's competence and skill in the chosen methodological approach. Commitment can be demonstrated through full engagement with the data, whilst rigour relates to the adequacy of the data collection and comprehensive analysis of the data.

Transparency and coherence are achieved through full exposition of the methods used in data collection and analysis, including the reflexive stance of the researcher. In grounded theory this reflexivity is inherent in the process of memo writing. The use of interview excerpts offers transparency and coherence by evidencing the grounded nature of the theory.

Furthermore, coherence refers to the fit between the subject under investigation and the chosen method for addressing this.

Yardley (2000) argues that the ultimate judge of any research is the importance to, and impact upon the desired audience. In this instance, this is likely to be the extent to which research has contributed to existing theoretical understandings of decision making in the assessment and intervention of post-traumatic stress symptomology in older people, and its usefulness to the profession of clinical psychology.

Researcher Expertise

In accordance with the epistemological stance described above, the researcher recognises that her own experiences and perspectives will influence her interaction with the data and thus the analysis.

The researcher is a 28 year old British trainee clinical psychologist with experience of working with older people as an assistant psychologist for one year, and then as a trainee clinical psychologist for a total of eighteen months. Experience was gained working therapeutically using a cognitive behavioural model with two older people who presented with post-traumatic stress symptoms. Additionally, lectures on the subject in the course of training had sensitised the researcher to the dominant models and theories within the area.

As a result of these combined experiences, the researcher developed an interest in the subject area and began the process of constructing a research proposal. In doing so, the evidence base relating to interventions for PTSD in older people was reviewed. The researcher acknowledges that these experiences increase the likelihood of interpreting the data in line with psychological constructs and will influence the analysis of the data.

The researcher had no previous experience using grounded theory and approached the task with both apprehension and enthusiasm. Considerable effort was made to gain an adequate level of competence in the methodology before commencing the project through reading texts, other grounded theory articles and undertaking practise exercises in coding.

Research Context

The project was undertaken in the third year of the researcher's Doctorate in Clinical Psychology, during a specialist placement in older people's psychological services. Participants were all qualified clinical psychologists working in health boards across Scotland. Whilst power is often seen as being held by the researcher in interviews (Weiss, 2008), in this instance, the dynamic was somewhat reversed, as a trainee interviewing experienced clinicians.

Participants and Ethical Considerations

Inclusion Criteria

Clinical psychologists who currently work with older adults or who have previously worked with older adults in their capacity as clinical psychologists; clinical psychologists who have worked (as the lead clinician) with a minimum of two older adult clients who have presented with post-traumatic symptomology; participants must have been based in Scotland at the time of participation.

Ethical Considerations

There were three main ethical considerations in the present study; firstly, ensuring the confidentiality of participants and clients mentioned by participants during interviews.

Secondly, ensuring participants were aware of being able to withdraw from the study at any time; and thirdly, that the analysis was faithful to the accounts provided by the participants. The first two considerations were addressed in the participant information and consent forms. All potentially identifying participant or client data were not transcribed and was destroyed in audio form once the transcription was complete. The third point is addressed via the adherence to the grounded theory methods selected and congruence with Yardley's (2000) principles of quality.

Ethical approval was granted by University of Edinburgh, School of Health in Social Science Research and Research Ethics Committee (see Appendix 3). NHS Research and Development approval was granted following the completion of the Integrated Research Application System by the following health boards: NHS Highland; NHS Fife; NHS Lanarkshire; NHS Greater Glasgow & Clyde; NHS Tayside; NHS Grampian; NHS Dumfries and Galloway; NHS Ayrshire & Arran; NHS Borders and NHS Lothian (see Appendix 4).

Procedure

Sampling

Sampling is purposeful in the first stage of data collection, and is intentionally not random. The aim is to select participants who have experience of the subject matter under investigation (Birks & Mills, 2011). In the current study the inclusion criteria set the parameters for the purposive sampling. Once a theory starts to emerge from the data, purposive sampling is considered to be complete and theoretical sampling is employed.

Theoretical sampling is "sampling on the basis of concepts derived from data" (Corbin & Strauss, 2008, p.65). Once a researcher has begun to identify properties and dimensions of

the categories, conceptual gaps will begin to emerge. Theoretical sampling entails either returning to data already collected to make further comparison or gathering new data with the specific intention of filling the gaps identified in the emerging theory. New data are compared to the emerging explanatory framework facilitating greater abstraction and explanation of variation.

Recruitment

Heads of older people's clinical psychology departments were identified by the researcher's clinical supervisor. An email was sent to all identified heads of department with participant information forms and consent forms attached, it was requested that they forward the email to all members of their department. The participant information form (see appendix 5) invited participants to contact the researcher by telephone or email with any questions or to express interest in participation. Interviews were arranged by the researcher when participants made contact and the consent form (see appendix 6) was signed.

Interviews

Interviews provide the opportunity for in depth exploration of participants' views and experiences of the subject under investigation (Weiss, 2008), and offered the best way of gaining insight into the internal decision making processes of clinical psychologists. A semi-structured interview format was adopted, using open questions to facilitate participant responses (see below). This format allowed the researcher to concentrate on the content of participant responses and follow up on areas of interest whilst having a structure to fall back upon, an approach advocated by Corbin and Strauss (2008) for novice qualitative researchers.

Interview Schedule

- Tell me how you go about conducting assessments and interventions with older people with posttraumatic stress symptoms.
- What do you draw upon in assessment?
- What models do you draw upon in interventions?
- It has been argued that we need to adapt how we work with older people in relation to posttraumatic stress symptoms, what are your views on that?
- When do you make changes to how you work, why and how?
- Are there any particular challenges of working with older people presenting with posttraumatic stress?
- Are there things you would do differently now given your experiences?
- Is there anything else you think I should know?

Follow up questions such as "can you tell me more about that" were asked to seek additional information and clarification where it was perceived to be relevant.

The interview schedule was scrutinised by an experienced grounded theory researcher and piloted on a fellow trainee clinical psychologist, following which adjustments were made.

The interview schedule was not adhered to rigidly as the researcher was guided by the content of responses provided by the participant, seeking clarification and elaboration at times. In order to encourage the interview to flow, time was taken before each one to develop rapport with the participant. Interviews were conducted in participant places of work.

Data Management

Consistent with the principle of transparency and coherence (Yardely, 2000), each interview was recoded on a digital recording device and transcribed verbatim. Client or participant identifying information was removed during transcription to ensure anonymity and confidentiality. On completion of transcription the audio recordings were deleted. Electronic copies of the interviews were retained and stored in accordance with Adherence to Scottish Executive Research Governance Framework (2006) and the Data Protection Act (2002).

Data Analysis

Transcription of the Data

Audio recordings were transcribed verbatim by the researcher using Express Scribe software. Whilst this represented a significant investment of time, some suggest that where recordings are transcribed by others, there can be omissions which are important to the analysis (Weiss, 2008). Thus in keeping with Yardley's (2000) principle of commitment and rigour, this task was undertaken by the researcher. Essentially, analysis began with transcription as the researcher was immersed in and became sensitised to the data (Corbin & Strauss, 2008).

Consideration was given to the use of computer assisted qualitative data analysis software (CAQDAS) such as Nvivo, and the literature consulted (Saillard, 2011; Schiellerup, 2008; Welsh, 2002). The researcher's view is that CAQDAS is in no way a substitute for manual coding and constant comparison. However the value of the software lies in its potential to help organise the data and the resulting memos. In view of the time it might have required for the researcher to become familiar with the software, a decision was taken to manually code and analyse the data, using familiar word processing software to organise the data.

Coding and Categorising the Data

Open coding is the first step in the process of analysis. It consists of applying a meaningful conceptual label to small segments of the data by interrogating and asking questions of it (Corbin & Strauss, 2008).

Open coding	**Transcript**
Responsibility Exercising caution Establishing expectations	Participant Eight: Although, I think with PTSD I would always be careful going in and assessing because I think you know, you don't know necessarily that the person sees that as the primary issue.
Trust Resources and demand Expectations	You don't know to what extent they'll want to discuss that, certainly not in the first interview (mmhhmm)
Noticing patterns Demonstrating empathy Engendering a sense of control Building trust Considering coping style	um and I think there are such issues of control with PTSD um, that it's, I think it's really vital to make sure that the person um, feels understood, but equally knows that they have the control and that you're not going to launch into um asking them about things that they really, that they've spent perhaps years and years trying to keep a lid on (yeah).

A paradigm proposed by Corbin and Strauss (2008) encourages the researcher to consider the data from three directions when coding: first, there are conditions, why, where, how and what happens; second there are inter/actions and emotions; and third there are consequences (of inter/actions and emotions). It is stressed however by Corbin that "being overly concerned about identifying "conditions" or "strategies" or "consequences" in data rigidifies the process" (Corbin & Strauss, 2008, p.90). Corbin's suggestion is that the paradigm is merely a tool to encourage thinking about the data.

Analysis is characterised by constantly comparing the codes developed from initial interviews with one another for similarities and differences. Initial codes are then compared to subsequent data, further refining the concepts to account for variation and context. Through the process of constant comparison and memo writing (see below), some codes are deemed to offer a better account of the data and thus are provisionally raised to the level of category, where they are checked via constant comparison to one another and the subsequent data. Groups of similar codes are amalgamated into categories with the codes explaining the context, variation, properties and dimensions of the category (Corbin & Strauss, 2008).

Axial coding is a further stage in analysis defined as a "set of procedures whereby data are put back together in new ways after open coding by making connections between [and within] categories" (Strauss & Corbin, 1990, p.96). Open coding and axial coding are not linear processes that run one into the other, but take place in response to the emerging theory throughout analysis (Corbin & Strauss, 2008).

This iterative process continues, with categories compared to codes and one another, revealing gaps which are addressed through theoretical sampling (Birks & Mills, 2011). Constant comparison enables the researcher to both check the fit of the codes and categories with the data, but also to develop categories which have well defined explanatory power.

Memo Writing

Memos are integral to the process of developing grounded theory and are congruent with Yardley's (2000) principle of rigour, in as much as analysis takes place through the process of writing memos. The researcher is encouraged to keep memos from the inception of the project and to record their thinking throughout. "Memos and diagrams begin as rather rudimentary representations of thought and grow in complexity, density, clarity and accuracy as the research progresses" (Corbin & Strauss, 2008, p.118). In addition, memo writing

adheres to the principle of transparency and coherence (Yardley, 2000), as it provides an audit trail of the researcher's decision making and reflexivity. An example of a memo is provided below:

Memo: Staying within therapeutic comfort zone, competence level

I've got a guy with epilepsy so EMDR's not a good idea (yes) and I'm not used, my EMDR supervisor said oh you could use the whole tapping and all that business but I'm not that, I don't feel confident enough yet with EMDR yet let alone starting tapping people (laughing). P6

This is something I haven't given that much thought to, but reading this seemed to make sense of what a number of participants have talked about in terms of 'following familiar procedures'. What they are doing is very much staying within their perceived competence level or comfort zone. I wonder if this is more the case because there is a greater sense of 'responsibility' working with PTSD and the need to be able to 'balance demands and resources'.

There does seem to be greater uncertainty regarding reprocessing work than other work, which for those who feel less confident this is harder to manage. For those with greater confidence, this is an aspect of the work that is enjoyed (P7).

I suppose therapist avoidance is closely linked with this, which again seems to relate back to responsibility and a fear of causing harm. P7 talks about managing the uncertainty of how a client will respond in the time after an exposure session. Is there something then about trusting the evidence base? There does seem to be an idea that this work is scary for some, and that is hard to balance with knowing what the evidence base suggests and also client avoidance.

Identifying a Core Category

The core category should offer explanatory power over all other categories and in this way further raises the conceptual level of the theory. It is suggested that at times the core category exists within the categories and is there for the researcher to identify. Other times none of the categories are seen as having sufficient explanatory power and a further code is developed, of which the existing categories form the properties and dimensions (Corbin & Strauss, 2008).

Theoretical Saturation

The definition of theoretical saturation utilised is that proposed by Corbin and Strauss (2008, p.263):

> "the point in analysis when all categories are well developed in terms of properties, dimensions and variations. Further data gathering and analysis add little new to the conceptualization, though variations can always be discovered".

Member Checking

Consistent with the principle of transparency and coherence (Yardley, 2000), a draft of the emerging theory was sent to the participants for their comment, a procedure known as member checking (Lincoln & Guba, 1985). Six of the eight participants replied, each reporting that the model appeared to account for the variation in their decision making. Two participants commented on aspects of the model which they believed may benefit from further elaboration. On reflecting on these points, the researcher determined that the model did account for the issues raised, however this was not made clear in the version participants received. Therefore the issues raised were further elaborated upon in a later draft.

Reflections on the Research Process

The process of undertaking a first grounded theory study has certainly been a challenge with a steep learning curve. The use of memos took time to get used to and initially there was scepticism about the utility of the exercise. However, the researcher quickly came to realise that writing memos is integral to analysis. They became essential tools through which thoughts were raised to a conceptual level and understanding developed regarding the relationships between codes and categories. Consulting with supervisors more experienced in the methodology was essential, particularly when analysis seemed to stall and when feeling

uncertain of the next step. At times it felt as though there was a danger of 'drowning in the data', which was disconcerting and yet reassuring that the researcher's experience was in keeping with the spirit of the methodology.

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APPENDICES

APPENDIX 1: Author Guidelines for Clinical Psychology Review (Relevant sections)

Article structure

Manuscripts should be prepared according to the guidelines set forth in the Publication Manual of the American Psychological Association (6th ed., 2009). Of note, section headings should not be numbered.

Manuscripts should ordinarily not exceed 50 pages, *including* references and tabular material. Exceptions may be made with prior approval of the Editor in Chief. Manuscript length can often be managed through the judicious use of appendices. In general the References section should be limited to citations actually discussed in the text. References to articles solely included in meta-analyses should be included in an appendix, which will appear in the on line version of the paper but not in the print copy. Similarly, extensive Tables describing study characteristics, containing material published elsewhere, or presenting formulas and other technical material should also be included in an appendix. Authors can direct readers to the appendices in appropriate places in the text.

It is authors' responsibility to ensure their reviews are comprehensive and as up to date as possible (at least through the prior calendar year) so the data are still current at the time of publication. Authors are referred to the PRISMA Guidelines (http://www.prisma-statement.org/statement.htm) for guidance in conducting reviews and preparing manuscripts. Adherence to the Guidelines is not required, but is recommended to enhance quality of submissions and impact of published papers on the field.

Essential title page information

Title. Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible. **Note: The title page should be the first page of the manuscript document indicating the author's names and affiliations and the corresponding author's complete contact information.**

Author names and affiliations. Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name, and, if available, the e-mail address of each author within the cover letter.

Corresponding author. Clearly indicate who is willing to handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address.**

Present/permanent address. If an author has moved since the work described in the article was done, or was visiting at the time, a "Present address'" (or "Permanent address") may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Abstract

A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.

Highlights

Highlights are mandatory for this journal. They consist of a short collection of bullet points that convey the core findings of the article and should be submitted in a separate file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point).
See http://www.elsevier.com/highlights for examples.

Keywords

Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural

terms and multiple concepts (avoid, for example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Abbreviations

Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

Footnotes

Footnotes should be used sparingly. Number them consecutively throughout the article, using superscript Arabic numbers. Many wordprocessors build footnotes into the text, and this feature may be used. Should this not be the case, indicate the position of footnotes in the text and present the footnotes themselves separately at the end of the article. Do not include footnotes in the Reference list.
Table footnotes
Indicate each footnote in a table with a superscript lowercase letter.

Electronic artwork
General points
• Make sure you use uniform lettering and sizing of your original artwork.
• Embed the used fonts if the application provides that option.
• Aim to use the following fonts in your illustrations: Arial, Courier, Times New Roman, Symbol, or use fonts that look similar.
• Number the illustrations according to their sequence in the text.
• Use a logical naming convention for your artwork files.
• Provide captions to illustrations separately.
• Size the illustrations close to the desired dimensions of the printed version.
• Submit each illustration as a separate file.
A detailed guide on electronic artwork is available on our website:
http://www.elsevier.com/artworkinstructions

Figure captions
Ensure that each illustration has a caption. Supply captions separately, not attached to the figure. A caption should comprise a brief title (**not** on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Tables

Number tables consecutively in accordance with their appearance in the text. Place footnotes to tables below the table body and indicate them with superscript lowercase letters. Avoid vertical rules. Be sparing in the use of tables and ensure that the data presented in tables do not duplicate results described elsewhere in the article.

References

Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the Publication Manual of the American Psychological Association, Sixth Edition, ISBN 1-4338-0559-6, copies of which may be ordered from http://books.apa.org/books.cfm?id=4200067 or APA Order Dept., P.O.B. 2710, Hyattsville, MD 20784, USA or APA, 3 Henrietta Street, London, WC3E 8LU, UK. Details concerning this referencing style can also be found at http://humanities.byu.edu/linguistics/Henrichsen/APA/APA01.html

Citation in text
Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

Web references
As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if

known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

References in a special issue
Please ensure that the words 'this issue' are added to any references in the list (and any citations in the text) to other articles in the same Special Issue.

Reference style

References should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters "a", "b", "c", etc., placed after the year of publication. **References should be formatted with a hanging indent (i.e., the first line of each reference is flush left while the subsequent lines are indented).**

Examples: Reference to a journal publication: Van der Geer, J., Hanraads, J. A. J., & Lupton R. A. (2000). The art of writing a scientific article. *Journal of Scientific Communications*, 163, 51-59.

Reference to a book: Strunk, W., Jr., &White, E. B. (1979). *The elements of style.* (3rd ed.). New York: Macmillan, (Chapter 4).

Reference to a chapter in an edited book: Mettam, G. R., & Adams, L. B. (1994). How to prepare an electronic version of your article. In B.S. Jones, & R. Z. Smith (Eds.), *Introduction to the electronic age* (pp. 281-304). New York: E-Publishing Inc.

APPENDIX 2: Author Guidelines for the Journal of Loss and Trauma (Relevant sections)

Instructions to authors – Journal of loss and trauma

Submission of Manuscripts

The manuscript should be prepared using MS Word or WordPerfect and should be clearly labeled with the authors' names, file name, and software program. Each manuscript must be accompanied by a statement that it has not been published elsewhere and that it has not been submitted simultaneously for publication else-where. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. All accepted manuscripts, artwork, and photographs become the property of the publisher.

All parts of the manuscript should be typewritten, double-spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. All titles should be as brief as possible, 6 to 12 words. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. Each article should be summarized in an abstract of not more that 100 words. Avoid abbreviations, diagrams, and reference to the text. Authors should also submit a list of about five keywords. Please consult our guidance on keywordshere .

Manuscripts, including tables, figures, and references, should be prepared in accordance with the Publication Manual of the American Psychology Association (Fourth Edition, 1994). Copies of the manual can be obtained from the Publication Department, American Psychological Association, 750 First Street NE, Washington, DC 20002-4242; phone (202) 336-5500.

APPENDIX 3: ETHICAL APPROVAL

School of Health in Social Science
Medical School, Teviot Place
Edinburgh
EH8 9AG

Telephone: 0131 650
Fax: 0131 650 3891

Email: submitting.ethics@ed.ac.uk

Jane Billett
Kenville
Station Road
Evanton
Dingwall
Ross-Shire IV16 9YW

Dear Jane

Re: **Decision making by clinical Psychologists relating to older adults with post-traumatic stress symptoms: a grounded theory**

Application for Level 2-3 Approval
****

Thank you for submitting the above research project for review by the Section of Clinical Psychology Ethics Research Panel. I can confirm that the submission has been independently reviewed and was approved. Should there be any change to the research protocol it is important that you alert us to this as this may necessitate further review.

With best wishes,

Yours sincerely,

pp Dr. Suzanne O'Rourke

APPENDIX 4:

Professor Angus Watson
Research & Development Director
NHS Highland Research & Development Office
Room S101
Centre for Health Science
Old Perth Road
Inverness
IV2 3JH

Tel: 01463 255822
Fax: 01463 255838
E-mail: angus.watson@nhs.net

NHS Highland

12 December 2012

NHS Highland R&D ID: **885**
NRSPCC ID: **NRS12/MH86**

Mrs Jane Billett
Trainee Clinical Psychologist
Drumossie Unit
New Craigs Hospital
6 – 16 Leachkin Road
Inverness
IV3 8NP

RECEIVED
19 DEC 2012

Dear Mrs Billett,

Management Approval for Non-Commercial Research

I am pleased to tell you that you now have Management Approval for the research project entitled: **'Decision Making by Clinical Psychologists Relating to Older With Post-Traumatic Stress Symptoms: A Grounded Theory'.** I acknowledge that:

- The project is sponsored by NHS Highland.
- The project does not require external funding.
- Research Ethics Committee approval is not required for the project as it involves NHS staff only.
- The project is Site-Specific Assessment exempt.

The following conditions apply:

- The responsibility for monitoring and auditing this project lies with NHS Highland.
- This study will be subject to ongoing monitoring for Research Governance purposes and may be audited to ensure compliance with the Research Governance

Framework for Health and Community Care in Scotland (2006, 2nd Edition), however prior written notice of audit will be given.

- All amendments (minor or substantial) to the protocol or to the REC application should be copied to the NHS Highland Research and Development Office together with a copy of the corresponding approval letter.
- The paperwork concerning all incidents, adverse events and serious adverse events, thought to be attributable to participant's involvement in this project should be copied to the NHS Highland R&D Office.
- Monthly recruitment rates should be notified to the NHS Highland Research and Development Office, detailing date of recruitment and the participant trial ID number. This should be done by e-mail on the first week of the following month.

Please report the information detailed above, or any other changes in resources used, or staff involved in the project, to the NHS Highland Research and Development Manager, Frances Hines (01463 255822, frances.hines@nhs.net).

Yours sincerely,

Professor Angus Watson
NHS Highland Research and Development Director

cc Frances Hines, R&D Manager, NHS Highland Research & Development Office, Room S101, The Centre for Health Science, Old Perth Road, Inverness, IV2 3JH
Pamela Shand, Senior Administrator, NHS Research Scotland Coordinating Centre, Research & Development Office, Foresterhill House Annexe, Foresterhill, Aberdeen, AB25 2ZB

APPENDIX 5:

PARTICIPANT INFORMATION SHEET

Clinical Psychologists working in Scotland with Older Adults are being invited to be involved in a research study being conducted as part of a Doctorate in Clinical Psychology. This sheet is to explain the reason for the study and what participation will involve so that you can decide if you wish to take part.

Please take the time to read the following information carefully. Please do not hesitate to contact me should you have any questions. My contact details are at the end of the sheet.

Project Title
Decision making by Clinical Psychologists relating to older adults with post-traumatic stress symptoms: a grounded theory.

Description of the study
This is a qualitative investigation of the process by which Clinical Psychologists make clinical decisions relating to the assessment and treatment of older adults (aged 65 years or above) who present with post-traumatic stress symptoms.

Why am I being invited to participate?
The study is interested in the experiences of Clinical Psychologists working with older people. You have been approached either because you are a member of PSIGE-SB or have been identified as a Clinical Psychologist working with Older Adults in Scotland.

Eligibility to participate in this study

- Clinical Psychologists currently working with older adults or who have previously worked with older adults in their capacity as Clinical Psychologists.
- Clinical Psychologists who have worked as the lead clinician with a minimum of two older adult clients who have presented with post-traumatic symptomology (it is not necessary for the clients to have met full criteria for post-traumatic stress disorder).
- Participants must be currently based in Scotland.

What will participation involve?
The data will be collected through semi-structured interviews lasting up to an hour. The focus of interviews will be the participants' experiences of making clinical decisions relating to post-traumatic stress symptomology in clients older than 65 years. Interviews will be conducted either face-to-face where it is feasible for the researcher to travel to the participant, or by video conferencing where this is not possible.

The interviews will be analysed using grounded theory methodology. The emerging grounded theory will be sent via email to participants. Participants will be offered the opportunity to comment on the theory. Comments can be made either via email or a further interview can be arranged at a time convenient to the participant. There will be no obligation to provide a comment either in writing or through interview. Participants can withdraw from

the study at any time without having to provide a reason and their data would be removed and deleted.

Confidentiality
Interviews will be audio recorded and transcribed into text form. During transcription any information identifying either clinician or clients will be removed from the transcription. Once transcription is complete the audio recording will be deleted.

A record of participants' names and contact details will be kept until data collection and analysis is completed (predicted to end in July 2013), to enable the researcher to contact participants. This will be kept in a secure location separate from the interview data and will be destroyed once analysis is complete. All the research data will be stored on a password protected memory stick which only the researcher and her supervisors will have access to. It will be kept for at least five years after completion of the study. The information provided will be treated in accordance with Data Protection Act 1998 and the Research Governance Framework for Health and Social Care (2006).

Direct quotes from the interviews may be used to present the results of the study however no identifying information will be included.

Ethical Review of the study
The project has been granted ethical approval by The University of Edinburgh, School of Health in Social Science Research and Ethics Committee and Research and Development approval in NHS boards across Scotland.

Dissemination of results
The completed study will be submitted to The University of Edinburgh as a Doctoral Thesis in Clinical Psychology. A journal article will be submitted to a peer reviewed journal. All participants will be sent a copy of the journal article.

How to participate in this research
If you are interested in participating in this study and meet the criteria above, please complete the attached consent form and return it to Jane Billett at the address below. On receipt of the consent form the researcher will contact you to arrange a time to conduct the interview. Please do not hesitate to contact me should you have any queries or wish to arrange to participate.

Thank you.

Contact details
Jane Billett, Trainee Clinical Psychologist, Drumossie Unit, New Craigs Hospital, Inverness, IV3 8NP

Supervisors:
Dr Mick Power, Professor in Clinical Psychology, The University of Edinburgh

Dr Andrew MacDougall, Consultant Clinical Psychologist, NHS Highland

APPENDIX 6:

PARTICIPANT CONSENT FORM

Decision making by Clinical Psychologists relating to older adults with post-traumatic stress symptoms: a grounded theory.

		Please Tick Box
1.	I confirm that I have read and understand the participant information sheet for the above study and have had the opportunity to ask questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.	☐
3.	I agree to take part in the above study.	☐
4.	I agree to the interview being audio recorded.	☐
5.	I agree to the use of anonymised quotes in publications.	☐
6.	I agree to being contacted by the researcher using the following contact details to arrange an interview.	☐

Participant email address:

Participant physical address:

Participant telephone number:

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Please send this signed form to:

Jane Billett, Trainee Clinical Psychologist, Drumossie Unit, New Craigs Hospital, Inverness